THE

Journal of the American Medical Association.

EDITED FOR THE ASSOCIATION BY N. S. DAVIS.

PUBLISHED WEEKLY.

Vol. VII. CHICAGO, DECEMBER 18, 1886. No. 25.

ORIGINAL ADDRESS.

RHINOLOGY IN THE PAST AND OF THE FUTURE.

An Address Delivered before the American Rhinological Association, on October 5, 1886, at St. Louis, Mo.

BY CARL H. VON KLEIN, A.M., M.D.,

OF DAYTON, OHIO.

No subject can present a higher interest than an inquiry into the past and future of rhinology. Whatever tends to correct error or introduce improvement into science must affect the comfort of the profession. No research on such a subject can be accounted too minute, no labor too long. Progressive as we have been in the past few years, we cannot boast of having revealed the last trace of civilization. When we look back to the history of rhinology, we find that as a specialty it is not of modern invention, as many suppose it to be. Egypt was the earliest home of medical skill, and every mummy of the more expensive and elaborate sort involved a process of anatomy, particularly as to its pathological condition, and these interesting pathological specimens were more numerous by reason of the profession being divided into specialties. Herodotus says:[1] Egypt claims the invention of healing art. The medical practice among the Egyptians is divided, and each physician is for one kind of sickness and no more, and all places are crowded with physicians, for there are physicians for the eye, physicians for the head, physicians for the nose, physicians for the teeth, physicians for the stomach, and for internal diseases.

It is claimed that the best anatomists among those specialists were those who practiced on diseases of the nose and stomach; they were the embalmers.[2] Embalming was first done by the rhinologist, removing a part of the brain through the nostrils by means of a crooked iron, and destroying the rest by injecting caustic drugs; and by the practitioners of the stomach, who made an incision along the flank with a sharp Ethiopian stone, and the whole of the intestines removed. The cavity was rinsed out by palm wine, and afterwards scoured with powdered perfumes. It was then filled with pure myrrh, pounded cassia and other aromatics, except frankincense. This done, the body was sewn up, and steeped in natron for seventy days. When the seventy days were accomplished, the embalmers washed the corpse and swathed it in bandages of linen cut in strips and smeared with gum. They then gave it up to the relatives of the deceased, who provided for it a wooden case, made in the shape of a man, in which the dead was placed.

Besides embalming, the rhinologists were also assigned as executioners in punishment of adultery, which was inflicted upon adulterers by amputation of the nose. Strabo says:[3] Rhinocolura is so called from the colonists whose noses had been mutilated. Some Ethiopians invaded Egypt, and instead of putting the malefactors to death, having cut off their noses they settled them at Rhinocolura, supposing that they would not return to their own country, on account of the disgraceful state of their faces. This gave those specialists opportunities for inspecting a vast amount of material, varying in every possible pathological condition. Such opportunities were sure to be turned into account by the more diligent among the faculty. Their reputation was so widely established that[4] Cyrus and Darius, kings of Persia, sent to Egypt for physicians. The former was afflicted with nasal polypi, the latter with ophthalmia.

From all historical accounts it is demonstrated that rhinology was one of the most cultivated specialties in the art of medicine. I have no doubt that rhinoscopic examinations were made by the Egyptians as well as they are made to-day. The use of mirrors among them was so common that they not only used them in their residences, but even as ornaments on their garments, and arranged them in their hair. And in the Egyptian temples, it was the custom for women to worship in linen garments, holding a mirror in the left hand and a sistrum in the right. Sir G. Wilkinson says[5] that the mirrors were susceptible of a lustre which has only been partly revived at the present day.

The treatment in rhinology we may imagine was absurd; yet Hippocrates described the same treatment of inhalation, fumigation and inspiration of essential oils, just as it is used at the present day.

In the treatment of syphilis, fumigations were extensively applied in clearing away the incrustations which generally exist in syphilis of the nose. Injection of lotions have been used from time immemorial. As to the success, whatever it might have been, we are unable to find any records thereof. Various compilations are in existence of the relative sum of the

[1] Ill. in loco.
[2] Herod., ii, 86–89.
[3] Strab., xvi, 2.
[4] Smith's Dict., p. 1060.
[5] Ancient Egypt, iii, 384.

disease of the various organs, but none pertaining to rhinocal. If there is such in existence, we can only expect an approximation to accuracy. Rhinology, like many other specialties of this century, began by men incompetent for the task. Any data, therefore, from this source, are too uncertain for philosophical deduction.

Medicine is no doubt one among the many lost ancient sciences. From the period of the cultivated Egyptians to about the fifteenth century, very little was known of the science of medicine. From Hippocrates to the days of Galen, a period of about six hundred years, and from the time of Galen to Fracastora, a period of about thirteen centuries, the science of medicine was like a barren desert. At the beginning of the sixteenth century she began to break the clouds which overspread the skies of blue, and the cultivation of medicine made its progress from day to day; though in the rear of other sciences, yet she is amid civilization.

It was not until the beginning of the present century, when the scopic method was thought of, that physicians became able to make a correct diagnosis of diseases. Great has been the usefulness of the urethroscope, rectoscope, stethoscope, ophthalmoscope, otoscope, microscope, laryngoscope, and only within the last few years the rhinoscope. Considering the numerous difficulties, and the multitude of conflicting theories which had from time to time been promulgated, on account of the parts and by reason of their being hidden from view, the pathological theories of nasal diseases were absurd and unphilosophical. Yet, with all its antagonism, it has in a great measure unveiled itself before the light of modern investigation, and become reduced to a more scientific basis, though we cannot boast, however, we opened a new road to medical science.

Our first acquaintance with some sort of an illuminator of the upper respiratory tract is mentioned by Levret, of Paris,[6] in 1743. In 1803, Bozzini[7] invented a kind of hand mirror for the purpose of examining all sorts of obscured cavities in the human body. In 1827,[8] Senn, of Geneva, proposed to examine the larynx by a small mirror, by introduction into the mouth. In 1829, Dr. Babbington,[9] of London, invented an instrument which he termed glottiscope, and also some sort of a tongue depressor of polished steel combined with a mirror. In 1832,[10] Kaslinsky, of Warsaw, invented a combined mouth speculum and gag. In 1835,[11] Plate, of Amsterdam, describes a double mirror for the examination of the larynx and pharynx. In 1837,[12] Selligue, a very intelligent machinist of Paris, who himself was subject to laryngeal phthisis, invented a laryngeal speculum consisting of two tubes, through which light was thrown into the glottis, and by a counter glass, which he placed in his guttural extremities, he was able thereby to view his own disease. In 1838,[13] Baumès, of Lyons, demonstrated a laryngeal speculum which cannot be found anywhere described. In 1840,[14] Liston, of London, applied in the examination of the larynx a dental mirror with a long handle, similar to that of Babbington. In 1844,[15] Dr. Warden, of Edinburgh, introduced a contrivance made of an argand burner lamp, for the examination of the glottis. In the same year Avery, of London, is said to have invented a successful instrument, for the purpose of examining the dark parts of the upper respiratory organs. In 1855,[16] Garcia, a Spanish vocalist and teacher in the City of London, wrote a paper entitled "Physiological Observations on the Human Voice," which he read before the Royal Society, wherein he explains in what manner a large reflecting mirror, with a small dental mirror in the mouth, can be made to exhibit the anatomy and the physiological actions of the laryngeal and pharyngeal organs.

At this time a period of half a century has elapsed, with discoveries from year to year to open a path to rhinology, yet not until 1847[17] the illustrious Dr. Türck, of Vienna, perfected a laryngoscope upon the same order as that invented by Garcia, of which he claimed to know nothing; it was much superior but of great resemblance to Garcia's. In 1859,[18] Dr. Czermak, of Pesth, and Dr. Gruber, of Krakau, with the assistance of Dr. Türck, experimented with the latter's instrument, until they had opened a broad road to the obscure places which we are here to discuss.

The system of rhinology has made a rich harvest of natural discovery which benefited mankind more than any progression in medical science made in this century, save anæsthetics. No organs within the human system can be so disclosed and show their pathological conditions, as those affected by the laryngoscope and rhinoscope. I speak of the laryngoscope, because rhinology and laryngology work hand in hand, and the former developed itself through the latter; and through Türck's invention of the laryngoscope we are indebted to Czermak for the invention of the rhinoscope. Since he has demonstrated the pathological conditions of the upper respiratory tract by illumination, many have tried to improve upon the process of illuminating the nasal pharyngeal cavities, with many good and important results.

The improved methods of Schroeder, Schnitzler, Senefelder, Cramer, Voltolini, Stoerk, Lewin, Traube, Fraenkel. Hirschberg, Ruete, Merkel, Waldenburg, Krishaber, Middeldorpf, Gerhard, Ziemssen and Tobald, of Germany; Rauchfuss, Poznisky, Ritter and Volltzior, of Russia; Mandl, Maura Bourouillon, Batrille, Cusco, Trauvel and Beverbire of France; Mackenzie, Gib, Johnson and Boxt, of England, and so many others of this side of the Atlantic, that it would require an entire volume to name them all.

Through their constant effort to improve the illuminary apparatus they have made many valuable ob-

[6] Phthisie laryngée. Paris, 1837, S. 177.
[7] Hufeland's Archiv der Heilkunde. Neue Folger, 17 Band.
[8] Gazette Hébdomadaire de Médecine et de Chirurgie. Paris, 1863, p. 263.
[9] Phthisie laryngée. Paris, 1837, S. 177.
[10] Woyenie Medicinsky Shornall. St. Petersburg part., L. xii.
[11] Plate's Voordragt over des Keelknobbel onderzœking. Amsterdam, 1836, p. 13.
[12] Illustrated by Morell Mackenzie. Third Ed., London, 1871.
[13] Trousseau et Belloc. Paris, p. 180.
[14] Liston's Practical Surgery. London, 1841.
[15] London Medical Gazette, 1844, vol. ii, p. 256.
[16] Gazette Hélebdom. de Méd. et de Chir., 16 Nov., 1855.
[17] Zeitschrift der Ges. der Aertze zu Wien., April, 1858.
[18] Czermak, Der Kehlkopfspiegel und seine Verwerthung für Physiologie und Medicin, 2 Auflage. Leipzig, 1863.

servations within the nasal cavities, necessitating the invention of many other instruments, such as rhinoscopic mirrors, nasal speculums, tongue depressors, palate hooks, uvula holders, nasal douches, nasal syringes, nasal spouts, nasal sprays, nasal catheters, nasal inhalers, nasal sponge holders, nasal forceps, nasal probes, nasal respirators, nasal powder blowers, nasal tampons, nasal snares, nasal écraseurs, nasal retractors, nasal cannals, nasal scissors, nasal brushes, nasal caustic holders, nasal evaporators, nasal dilators, nasal camesoils, nasal plugs, nasal gauges, nasal drills, nasal blowers, nasal burs, nasal saws, nasal trocars, nasal spoons, nasal knives, nasal curettes, nasal clamps, nasal applicators, nasal fumigators, nasal cauterizers, nasal cauterys, nasal electrodes, etc.

The rhinoscope evidently brought to light the necessity of inventing the appliances mentioned, and their inventors, in order to complete them, were forced to experiment with them, and by their experiments many observations were made, to such an extent, that it had made many deaf ears hear, and many blind eyes see, because many of those afflictions are caused by rhinocal disease, to say nothing of the numerous other kindred diseases, to which the upper respiratory tract is the sole cause. It has lately been discovered that many of the lower respiratory organs cannot be healed until the disease of the nasal cavities is cured. The dreadful disease, asthma, which has always been considered a nervous disease, has recently been successfully treated by the removal of a large hypertrophy of the posterior nares.[19] Others, as I, have cured cases of nervous prostration by healing the nasal pharyngeal cavities, and many other organs connected therewith. Such affections may frequently be observed in the bladder, liver, kidney, stomach and brain.

In 1881 I succeeded in curing a case of epilepsy of two years standing by the removal of two large polypi of the posterior nares. The patient was a girl 11 years old. In the same year I successfully treated a case of insomnia by the same operation as in the former case. Last year I cured a case of supposed insanity by extirpating a large turbinated process. Indeed, there is scarcely an organ or structure of the body in which they are not occasionally affected by nasal disease; it stands to reason; the nose is the gate to disease; in nine cases out of ten the causes of human ailments pass through the pathway of the nasal cavities. If an inhalation of obnoxious gases can enter the lower intestines and produce a typhoid fever, why cannot it enter to the other organs or structures of the upper and lower extremities? When a piece of heavy artillery passes along the highway it can be traced from the very spot the wheel commences to revolve; it leaves its impression from the starting point to its destination. All diseases caused by exposure, or inhalation, must evidently make their first impression within the gate, the nose. It would therefore be better in all cases that rhinoscopic examinations should be made whatever the disease may be, the gate should be first examined.

The nose is the foundry of a large machine-shop, wherein disease appears in its rough casting. Other organs are finishing rooms, wherein they appear entirely developed. In fact, the whole human body is comparatively a machine, and such a machine should be handled by different machinists; as all the cogs are connected, therefore they ought to be understood by each mechanic the connection of the entire machine; as a single cog, in a single wheel, is no doubt but a small part of its mechanism, and can contribute but a small portion to the effect of the entire work; yet the want of its coöperative influence may, if not entirely stop, yet greatly impede its motion. It is ever so with the physician, though he ought to understand every physiological action, and its anatomical connection with every part within the human body, yet, I hold that he ought to practice only a specialty. If a mechanic, for example, a fabric, wood, or a metal worker, who requires simply physical training, can produce better special work, why not a physician make better cures if he confines himself to a specialty? If a cabinet maker can make a better bureau than a bedstead, or a pants-maker can make a pair of pants better than a coat-maker, or a metal-worker can produce better filing than an anvil-worker, or *vice versa*, why not a cultivated physician with an active brain and mind, who devotes himself to one special subject, make a better physician? A man who devotes his mind and trains his eye to microscopy, makes a competent microscopist; why not he who devotes his time and trains his mind to the ophthalmoscope, make a good ophthalmologist? or a laryngoscopist a laryngologist? and a rhinoscopist a rhinologist? Above all, I believe that rhinoscopy is one of the hardest studies of all. It takes more perseverence, patience and assiduity to make a correct rhinoscopic diagnosis than in all other "scopics." Only such persons who are constantly devoting their time to rhinocal pathology are qualified.

Specialism is a discovery of lost thought in medical art. Sooner or later we will all be specialists, but not until the common prejudice has vanished and the narrow-minded will cease to influence those who are eager to learn the truth. Dr. Crosby, of Manchester, President of the New Hampshire Medical Society, in his Annual Address says:[20] "Shall the practice of medicine sink to the level of a trade, where every competitor supplements his skill as an artisan by all the tricks of cunning and diplomacy of which he is able? Shall the body of the profession be broken up into fragmentary joints, each little segment calling itself a specialist, until the organs of the body are parcelled out as booty is divided among thieves? Shall the grand old column be broken up into detachments that shall ultimately destroy one another, because men honestly differ as to means employed to subdue disease?"

Just think of such irreverent assertions by men who ought to seek the truth which is before them, and forsake the errors of the past. But, gentlemen, fear it not; such is like the wretched ghosts of the idle and the inglorious in the Inferno of Dante, who did neither good nor harm while on earth, and who

[19] Jour. Am. Med. Ass'n, vol. vi, 1886, p. 696.

[20] Boston Med. and Surg. Jour., vol. cxv, 1886, p. 15.

are in consequence debarred all admission into heaven and hell as having no direct character for either place:

> Cacciarlii Ciel per non essermen bello;
> Nè lo profondo Inferno gli riceve.

The remarks of Dr. Crosby are heretical to the sentiments daily advanced by great men of medicine. Our beloved lamented late Dr. Austin Flint gives the following to the world with the last stroke of his pen:[21] "The unavoidable subdivision of medical literature and medical instruction into special departments makes necessary, to a certain extent, specialism in the practice of medicine. It is certain that this will not lessen, but increase in the near future, and it is important to think of possible emergencies which are even now foreshadowed. Specialism conduces to the advancement of knowledge. It behooves us, however, to consider, where the practice of medicine is to be given up to specialists, what would become of the medical profession? With due appreciation of services devoted to special branches of medical knowledge, there are tendencies pertaining to the practice of a specialty that should not be overlooked."

Dr. Angell, of Rochester, President of the Medical Society of Central New York, in his Annual Address, says:[22] "It is an undeniable or selfevident fact, that at the present day medical science has expanded to such an extent that its intelligent cultivation as a whole, by one person, has become impossible."

The body of the medical profession should and must "be broken up" into "specialisms." It should not remain as "a Jack of all trades and master of none." "The grand old column" which has been standing for so many years, must be repaired and decorated with fine jewels to meet the present demand in medical science, that she may glitter in the midst of other sciences. Nor "shall certain methods be considered Catholic, and all else irregular and to be damned by bell, book and candle."

If rhinology had to depend on the treatment recommended by writers of general medicine, she could not reach the bright future before her. We must take cognizance of the fact that her future is filled with admiration of the striking phenomena, having an inexhaustible mine of pathological developments lying dormant within the reach of those who wish to adjure them. For there is no condition, no period of life that can claim immunity from disease within the nasal cavity.

It is said that about nine-tenths of the human family are more or less afflicted with rhinocal disease, and which were not observed on account of insufficiency in rhinocal appliances.

Here a wide and wonderful chasm occurs, which cannot be, as formerly, overlooked. The illumination by the rhinoscope, the examination by the microscope, the extirpation by electro-cautery, the inspiration by the spray, and by the true, honest and conscientious method of our friend Dr. Rumbold, will make rhinology fruitful and progressive. If we will not remain idle, many important facts will be unveiled and rhinology will be the greatest in the whole domain of medicine. The microscope will reveal new pathological organic disease of the olfactory sense. The variety of nasal catarrh will be divided by each individual characteristic discharge, having its own nomenclature, according to their morbid condition.

The various muco-purulent discharges which originate in the different sinuses, will, as well, be recognized by microscopic examination. All the hypertrophies within the nasal chambers will bear their own pathological name. The eruptions and ulcers in the nose will be regarded like the variety of eczema. The abscesses, polypi, and all other foreign bodies within the nasal cavities will be assigned to their own nomenclature. By a combination of the rhinoscope and the microscope diagnosis will be made easy and certain.

The treatment in nasal diseases might change in the use of drugs and remedies, but in the manner in which it is applied the spray and Rumbold's method will remain certain and without end. The day is not far when all diagnosis of the respiratory and their kindred organs will first be looked after in the upper respiratory tract. Hospitals and asylums will be well fitted out with rhinoscopic appliances for the purposes of examining all those who may become inmates of these institutions. The public will become acquainted with this specialty as well as they are with the dental profession, so that the rhinologist will not have to depend mainly on practice which is sent or recommended by the general practitioner.

Gentlemen, from all the foregoing you will doubtless place me as a specialist. I am sorry to state that I am not; nor will I be untill the profession has adopted "the best policy," and that is, "honesty." I mean honesty with their professional brethren. I know of a physician in good standing befriended by all the practitioners (about one hundred in number) within his city, who three years back commenced to practice, as a specialty, diseases of the nose and throat; though he was encouraged daily while in conversation, however, during said period but a single patient was recommended to him. I hold this dishonesty; for the simple emolument of a few shekels they were but too willing to undertake to treat disease for which they are neither competent nor prepared.

There are theories which some men despise because they will not consider them, and which they will not consider, because they despise them. They naturally despise specialties, because they think them insufficient, and hate specialists, because they think them inferior; with such men, be cautious in your intercourse, as they always consider themselves greater; such men seldom confer obligations on their supposed inferiors but from interested motives. Friendly they appear, as long as it serves their own turn; but they will render no assistance in time of actual need.

In conclusion to the foregoing I will say, all those

[21] Flint's Medicine of the Future. The prepared Address for the Annual Meeting of the British Medical Association for 1886.
[22] Buffalo Med. and Surg. Jour., July, 1886, p. 567.

obstacles are indeed great, but to determined and persevering exertion they are not insuperable; though we cannot conceal them from ourselves, we should not allow them to daunt our spirit; let us comfort ourselves by devoting our time and talents for the good, not only for the world of medicine, but the world of man.

ORIGINAL ARTICLES.

PNEUMONIC FEVER IN PREGNANT FEMALES.[1]

BY EDWARD F. WELLS, M.D.,

PROFESSOR OF MATERIA MEDICA, PHARMACOLOGY AND CLINICAL MEDICINE IN THE COLLEGE OF PHYSICIANS AND SURGEONS, OF CHICAGO.

Recently I have had to treat an important case of pneumonic fever in a pregnant female, in the course of which several momentous questions of practice arose in such a manner as to again, forcibly and practically, bring before my mind a subject which had already attracted much of my attention.

Case 1.—Mrs. H. K., aged 31. On December 10, 1882, being two months advanced in her fourth pregnancy, she attended church, walked home, a distance of a mile, and was at once seized with a lacerating pain under the right nipple, followed by a severe rigor, fever, cough, expectoration, and all the ordinary symptoms of a moderately severe attack of pneumonic fever, with hepatization of the lower lobe of the right lung. The malady pursued an uneventful course, during which a profuse epistaxis, an abundant labial and nasal herpetic eruption and a low range of temperature were the only remarkable features. Crisis occurred on the seventh day, and she carried her child to full term. Thirteen months later she suffered a second attack, with implication of the left base, which ran a mild course and terminated by crisis on the fifth day. At this time she was pregnant about a month, but was unaware of the fact, and again abortion did not occur.

On March 13, 1886, being near full term with her sixth pregnancy, this lady was taken with her third attack of pneumonic fever. There was a severe rigor of three hours' duration, followed by ardent fever, agonizing pain in the left side of the chest in the axillary line, distressing dyspnœa, cough, expectoration of characteristic sputa, and the other ordinary symptoms of the disease. I first saw her on the evening of the second day, and found her with, besides the above-mentioned symptoms, a flushed and anxious countenance, a rapid pulse, vomiting, etc. Throughout the entire left lung there were abundant crepitant râles, with beginning dulness and tubularity at the base posteriorly. Her abdomen was greatly enlarged and the fœtal movements were vigorous and frequent. The malady gradually assumed a most alarming aspect, so that by the fourth night she was delirious and had a parched tongue and abundant sordes upon the teeth. At this juncture I advised the production of premature labor, but the measure was peremptorily declined by the patient. On the sixth day there was low, muttering delirium, with total unconsciousness of all surroundings, a pulse of 130, temperature of 104.2°, and a respiration rate of from 48 to 60 per minute. There was retention of urine, involuntary discharge of fæces, absence of expectoration and tracheal râles. At 5 o'clock P.M. I determined to deliver, having in view the saving of the child's life and the forlorn hope of improving, however slightly, the chances of my patient. I introduced deeply into the uterus a gum elastic catheter, which brought on contraction in about four hours, and the child, a boy, was safely delivered in three hours more. The placenta was found detached and was removed in a few minutes. There was about the usual amount of hæmorrhage.

For a few hours the condition of my patient was somewhat improved. Her pulse became less frequent, falling to 92, the temperature declined gradually to 99°, and the respiration to 40 per minute. Expectoration returned, the tracheal râles disappeared, and she became, at times, more rational. On the seventh day, however, distinct symptoms of puerperal mania manifested themselves, and, these increasing in severity, she died exhausted on the ninth day. For several hours before her death there was, clearly perceptible to all who approached near the patient, present a peculiar odor—the *odor mortis*. In this connection it is but fair to say that the pulmonary symptoms, as evidenced by the diminished frequency of the respirations and cough, the easy expectoration, the moisture of the râles, etc., continued to improve to the last, and that the fatal termination was clearly due to the complications. With a full and complete knowledge of all the circumstances attending the case, I feel satisfied that had not the puerperal mania—which has already repeatedly affected her mother and two sisters—attacked her, she would have recovered. An autopsy was not allowed.

Inasmuch as a certain and almost constant proportion of women within the limits of the child-bearing age are at all times pregnant, and as pneumonic fever is no great respecter of persons, as we shall presently see, it must follow that a definite percentage of pneumonic patients are pregnant females. The mutual influence which these conditions exercise upon each other must, in the light of the experience detailed, ever remain a subject of the deepest interest and one involving questions of the greatest practical importance. Some of these interrogations may be formulated as follows:

1st. What proportion do the pregnant females bear to the total population?

2d. What proportion of the females of child-bearing age are pregnant?

3d. Does pneumonic fever attack females more or less frequently than other classes of the population?

4th. In what manner is the course and terminations of the disease modified by the condition of pregnancy?

5th. In what proportion of these cases does abortion or premature delivery occur?

6th. What modifications of treatment are desirable or necessary?

I pass by the first and second questions as being

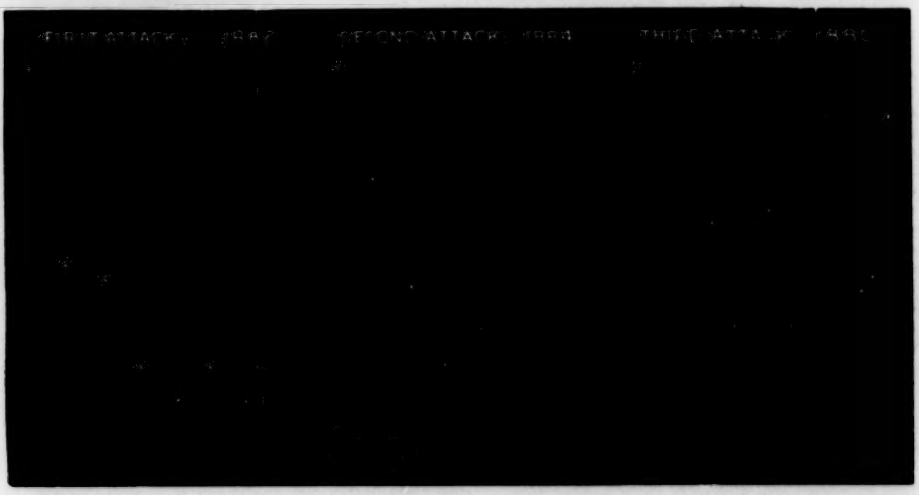
[1] Read by title in the Section on Medicine at the Thirty-seventh Annual Meeting of the American Medical Association.

of minor importance, and come at once to the third. Jürgensen[1] considers pregnant females as being less liable to attacks of pneumonic fever than other classes of the population. Of the 2475 female pneumonic patients treated in the Vienna General Hospital only forty-three were pregnant. From the total number of patients must be subtracted 611 who were over 50 years of age, and twenty-four who were under 15 years. There remains 1824 of child-bearing age, of whom forty-three, or 2.3 per cent., were pregnant. Of these forty-three, twenty-five aborted,[2] and of these twenty-five, seven died, a mortality of 28 per cent.[3] Of my 456 cases ninety-four were married females of child-bearing age, and of these eleven chanced to be pregnant. In these cases pregnancy had existed from one to three months, in four cases, and from six to nine months in seven cases. Of these eleven cases none of the first class aborted, and of the second class one at six months and two at eight months were prematurely delivered, and in the case related labor was brought on at near full term. The remaining seven cases carried to full term. All the patients, save one, recovered. The children were all born alive, but all except the one delivered at near term died very soon after delivery. Judging from the data afforded by Jürgensen's and my own statistics, I am clearly of the opinion that pneumonic fever is met with in pregnant females in fully as great a proportion as amongst the non-pregnant of the same age and condition. I must therefore dissent from the opinion of Jürgensen as above expressed.

[1] Ziemssen's Handbuch d. Spec. Path. u Therap., Bd. V, Leipsig, 1877, p. 28.
[2] Jürgensen, op. cit., p. 28.
[3] Jürgensen, op. cit., p. 127.

It has generally been considered that pneumonic fever pursues a more acute, rapid and severe course in the pregnant female, and that the danger is greatly augmented. This has not been the rule in my individual experience, although I do not deny that it might appertain in the practice of others. Thus Tyler Smith[4] says that "it is well known that blood drawn from healthy women during pregnancy generally shows the buffy coat, and it is found that all inflammatory diseases have a tendency to a more acute form than usual and require a more prompt and active treatment than under any other circumstances. This is particularly the case in inflammatory diseases of the chest." Peter[5] considers organic disease of the heart a common cause of acute pulmonary diseases in the pregnant female, and advises that women affected with heart disease should be cautioned against becoming pregnant, and should they unfortunately become so, prophylactic measures against pulmonary affections should be had recourse to.

Grisolle[6] long ago made the statement that more than one-half of the pregnant women attacked by pneumonic fever abort or are prematurely delivered, and subsequent experience only confirmed him in this belief.[7] Jürgensen's statistics[8] show a somewhat larger, and my own a somewhat smaller, proportion, but the number of cases is too small to serve as a basis for correct conclusions on numerical grounds. Judging from my individual observations and from the unpublished experience of others with whom I have conversed, I am of the opinion that it would



CHARTS, SHOWING TEMPERATURE, PULSE AND RESPIRATION RATE IN THE THREE ATTACKS.

[4] Lectures on Obstetrics, Lancet, N. Y., 1856, p. 523.
[5] L'Union Méd., Feb. 27 and March 5, 1872.
[6] Traite de la Pneumonie, Paris, 1841, p. 470.
[7] Arch. Gen. de Méd., Jan., 1850. [8] Op. cit.

be more correct to say that before quickening abortion will rarely occur, but after this time premature labor will take place in the majority of cases. Gusserow[9] and Ringe[10] have made some extensive studies concerning the conditions under which abortion or premature delivery occurs in the acute infective diseases, and have come to the conclusion that the increase in the body heat is the one exciting cause. They found that a temperature of 108° certainly caused the death of the child *in utero*, with consequent delivery; and that any temperature above 104° was pretty sure to be followed by the same result. Although a high temperature may be one of the causes of miscarriage in these cases, yet I am convinced that until additional proof is offered us that it is the only cause, we ought to render a verdict of "not proven" to the proposition of Gusserow and Ringe. In my cases there were two premature deliveries in subjects with a temperature of not above 102°, and there were two others in which pregnancy proceeded to full term in which the temperature exceeded 104°. In the case detailed at the beginning of this paper there were no symptoms of approaching labor, although the temperature exceeded 104° and the child was not destroyed. It is probable, therefore, that there are other factors, equally potent, besides the exalted temperature, which determine delivery in pneumonic fever. With the multitude of possible causes at play, each of which might be instrumental in causing delivery, it must be difficult or impossible to determine exactly the influence which each exerts.

It has been thought by some that the interference of the respiratory function by pregnancy and pneumonic fever might be a cause of premature delivery.[11] I have never been impressed with the idea that this is the case, although I hold that such embarrassment is an indication for the production of premature labor if the child is viable.

My cases, in abstract, are as follows:

Case 2.—Mrs. M. G., aged 27, six months advanced in her third pregnancy, was taken, April 21, 1880, with the ordinary symptoms of pneumonic fever, the base of the right lung being the part locally affected. At 7 P.M. the pulse was 118, respiration 24 and temperature 101.6°. During the night she slept from 12 to 4 o'clock, being awakened by commencing labor pains. At 6 A.M. the pulse was 109, respiration 24 and temperature 101°. The os uteri was dilated to the size of a silver dollar, the membranes had just ruptured and the cord and right shoulder presented. The faulty position was rectified and a dead fœtus was at once expelled, followed in a few minutes by the placenta. The pulmonary inflammation, beginning at the base of the right lung, gradually crept upward until the entire lung was affected. The case was further complicated by a metro-peritonitis. On the seventh day there were well-marked tracheal râles, delirium and a tendency to a comatose condition. By the thirteenth day, however, she was convalescent, and soon regained her ordinary health. A year later phthisis developed, and she died from this malady about eighteen months later.

Case 3.—Mrs. A. C., aged 26, seven months advanced in pregnancy, was attacked, March 20, 1880, with pneumonic fever, affecting locally the base of the left lung. The case ran a very severe course, with typhoid symptoms, but convalescence began on the eighth day and she carried to full term.

Case 4.—Mrs. H. F., aged 25, two months advanced in her second pregnancy, suffered an ordinary attack of pneumonic fever, locally affecting the base of the right lung, and recovered in ten days without abortion.

Case 5.—Mrs. J. B., aged 40, two months advanced in her sixth pregnancy, passed through a mild attack of this disease, affecting the right lung, in seven days without aborting.

Case 6.—Mrs. J. S., aged 35, eight months advanced in her sixth pregnancy, was seen, in consultation, just as she was entering upon convalescence from an attack of pneumonic fever, locally affecting the base of the right lung. She carried to full term.

Case 7.—Mrs. S. S., aged 20, seven months advanced in her first pregnancy, was taken, January 11, 1879, with the ordinary symptoms of pneumonic fever, affecting the base of the right lung. On the seventh and ninth days the pulse had fallen to 50, and the temperature to 96° and 95°. On the tenth day she was suddenly delivered of a living child, which died in two days. Two days later a very severe attack of diphtheria began, but she eventually recovered.

Case 8.—Mrs. F. R., aged 35, eight months advanced in her eighth pregnancy, was taken, December 2, 1878, with the ordinary symptoms of pneumonic fever, locally affecting the upper lobe of the left lung. The malady pursued an ordinary course, with a temperature curve not exceeding 102°, until the sixth day, when she was delivered of a living child, which died after a few hours. There were no premonitions of labor. She had been sleeping for hours when she was awakened by labor pains, and was at once delivered. Resolution began on the ninth day and the patient was soon well.

Case 9.—Mrs. H. W., aged 22, eight months advanced in her second pregnancy, was attacked, December 23, 1878, with pneumonic fever, locally affecting the lower and middle lobes of the right lung. The disease ran a mild course and the patient was convalescent on the eighth day, on which day there were threatenings of premature labor which were speedily relieved by appropriate treatment, and she carried to full term.

In those cases of pneumonic fever in which pregnancy does not cause any impediment to free breathing, I do not think the condition exerts any influence indicating a modification of my ordinary treatment of the disease. Miscarriage under these circumstances is a decided evil, and if it were threatened, measures should be instituted for its prevention—if this is possible. But if pregnancy be so far advanced as to cause a considerable encroachment upon the

[9] Berliner klin. Wochenschr., 1880, No. 17.

[10] Volkmann's klin. Vorträge, No. 174.

[11] Duncan (Lancet, 1884, vol. 1, p. 471) claims that, because the transverse diameter of the thorax is increased, the respiratory capacity of a female at full term is not always diminished.

respiratory capacity, from the amount of lung consolidation and upward pressure from the uterus, with dyspnœa and great rapidity of breathing, as in my first case, I am prepared to strongly advocate the production of premature labor. The advantages of this measure are that, if undertaken sufficiently early, the child's life is almost certainly saved, with very great relief to the patient, and, judging from my limited experience, a favorable impression upon the disease and a lessening of the danger and mortality attending it. I should advise, therefore, that premature labor should be brought on as soon as the respirations become very frequent or the dyspnœa pronounced.

It might be supposed that labor would very greatly increase the danger, but I feel assured that this is not the case, but rather the contrary. In quite a number of cases in which premature labor has occurred in the course of febrile diseases I have seen the temperature and pulse decline and the other symptoms ameliorated, even during the progress of labor, and this has also been the case in the few of my cases of pneumonic fever which were so complicated. I should be glad to see this question fully discussed, believing that valuable light can be shed upon an important class of cases.

PROPHYLAXIS MORE IMPORTANT THAN REMEDIAL TREATMENT.[1]

BY T. R. BUCKHAM, A.M., M.D., F.S.Sc. (LOND.).

OF FLINT, MICHIGAN.

Although I have not given the subject which this Section has in special charge as much consideration as I have bestowed upon some other departments of our professional field, yet, I beg to outline, rather than to particularize, the importance of prophylaxis, especially in early infant life; and, while according the fullest measure of importance to the scientific treatment of diseases of infants and children, I wish to emphasize, in the strongest manner, the opinion, that if ever the fearful mortality among infants shall be so reduced as to rescue it from being classed as an *opprobrium medicorum*, it must be done by united, persistent, scientific preventive, rather than by remedial measures.

While embryocide and fœticide, technically considered, are not a part of our subject directly, yet it is a most melancholy fact, that were the debasing crimes extirpated there would be an immense number added to those who are properly within our domain; hence, although not directly, it is indirectly, a proper and most important matter for our consideration. There are no data on which to even approximately determine the extent to which this vice is practised, for the obvious reason that it is declared to be a crime and punished as a felony; therefore there are most cogent reasons for the perpetrators keeping it strictly secret. Notwithstanding the fact, however, that we are unable to furnish definite proof of the extent, it is an open secret that the number of lives destroyed is very large. It is a surprising fact that there are many intelligent wives and husbands who yet believe, or affect to believe, that there is no life until after the third month of pregnancy; *ergo*, there is no crime in destroying the embryo. While we may not be able to convince such persons of the scientific fact, which they do not wish to understand, that there is life from the moment of conception, we may, at least, wash our hands of guilt, by taking the necessary time and trouble to demonstrate the truth to them, so that if they persist in perpetrating the most revolting of crimes—destroying the fruit of their own bodies—they shall do so fully warned of their moral turpitude, and also of the physical danger to the mother. Could we but close that one flood-gate through which pours such a stream of embryonic and fœtal life, we could save more lives than by our united armamentaria of infantile remedial agents.

Before considering the diseases that directly belong to our Section, please bear with me while I call your attention to some statistics which will aid us in the investigation of the subject. The figures have been kindly furnished by the able Secretary of the State Board of Health of Michigan, or taken from Ziemssen's "Cyclopædia of Medicine." Of all the deaths in Michigan about 40 per cent. are of children under 5 years old, 2.55 per cent. die between 3 and 4 years of age, 3.67 per cent. between 2 and 3, 6.82 per cent. between 1 and 2, and about 26 per cent. under 1 year; of those who die under 1 year old, more than half die under 2 months, and, one-third under 1 month old. Observe the astonishing rapidity with which the death-rate increases as we descend from 5 years of age toward birth. From 3 to 4, the percentage is 2.50, from 2 to 3, 3.⅔, from 1 to 2, 6.¾, and under one 26; 14 per cent. die under 2 months and more than 9 per cent. under 1 month old. To what extent can we reasonably expect our remedial agencies to control, in early infancy, the rapid course of disease which relentlessly hurries its tender victims to the grave, ere, as infants, they have fairly begun to live?

Have we always done our whole duty in actively, earnestly, warning the people, and in pointing out the road by which the danger, to some extent, at least might have been avoided? From about 9,000 deaths reported, occurring in the first year we find about 15 per cent. were nursed at the maternal font, while of those otherwise fed the percentage is 85; a difference of 70 per cent. in favor of natural feeding. Have we always earnestly and faithfully warned the devotees of fashion, who considered it little less than a calamity that they were mothers, of the onerous and sacred claim maternity laid upon them in the care of their offspring, and of the imperative duty of providing a healthy wet-nurse, if they could not, or would not themselves furnish their infants with natural sustentation? While urging in the strongest manner that mothers should nurse their children, of course exception must be made where, from debility, the life of the mother would be endangered by the tax upon her vitality by nursing, or where, from maternal disease, the milk would be injurious to the

[1] Read in the Section on Diseases of Women and Children, at the Thirty-Seventh Annual Meeting of the American Medical Association.

child. When, for sufficient reasons infants must be fed artificially, the most careful and minute details should be given to nurses and mothers as to the care and feeding of their delicate charges. I shall not occupy your time in stating what directions should be given, but I will say that I know of no more trustworthy directions than those given by Dr. Jacobi on the subject of infant feeding; and I would call especial attention to the value of barley-water as a diluent of the milk according to his recommendation. With the utmost deference, however, I remark that my experience, limited as it is in comparison with his, would lead me to dilute the milk to double the extent that he advises. Possibly the difference of opinion lies in the original richness of the milk used. In country towns we have plenty of fresh rich milk from Jersey cows; while in large cities I have often been served with milk so thin and blue that I judged its bulk had at least been doubled by too close proximity to the town pump.

While our chief attention should at first be directed to alimentation, I need not remind you that in the second year the source of danger largely changes from the alimentary to the respiratory system. "In the first year of life, stomach and intestines, in the second bronchi and lungs are the sources of increase of the death-rate. The respiratory organs are better protected habitually, in the first year and the digestive organs more improperly treated. Those infants who survive the first, are exposed to the same parental ignorance and carelessness concerning the requirements of the organs of respiration in the second." There is another factor in the diseases of infants and children which ought to be always born in mind: *i. e.*, the great relative disproportion between the weight of brain to body in infants as compared with adults. The weight of the male infant brain being in proportion to its body as about 1 to 5.85, while that of the male adult is about 1 to 46, and this proportion slightly diminished, is also true of the medulla spinalis, which wields such absolute sovereignty over infantile movements.[1] It naturally follows, that with nerve centres almost eight times as large in proportion in infants as they are in adults, that the nervous susceptibility and irritability must be very much more acute. so that it is not a surprise to us when we find that which would be a severe chill in a grown person, is generally a convulsion in an infant; hence, we cannot too carefully guard from irritation their brains and spinal cords on account of the augmented danger both direct and reflex. From the fact that there is so much more to be dreaded from the respiratory organs during the second year, we should consequently urge the absolute necessity for their being always warmly clad, breathing pure air, and being carefully guarded from sudden changes of temperature, and in many localities we may find it to be our imperative duty, unpleasant as the task would be, to even urge personal cleanliness upon the nurse or mother.

The advantages that would arise from well-directed efforts on the part of physicians, boards of health, and civic officers to enforce strict hygienic regulations among the poor and vicious cannot well be over-estimated; as, apart from the direct mortality involved, it is in such quarters that most of our epidemics have their origin, and thus they indirectly imperil the lives of thousands upon thousands. Much has already been done in this direction by boards of health, but very much remains yet to be done. Let us give such boards of health, and all agencies having a like object in view, our active aid, as individuals; and, as a profession, our earnest outspoken support; especially should this be the case in overcoming the repugnance of the ignorant, and sometimes of those who ought to know better, to having the subject of infectious or contagious diseases put under proper quarantine, or when quarantine is impracticable then to the enforcement of the most complete isolation possible.

I trust my motives will not be misconstrued, in referring here briefly to my plan of prophylaxis of diphtheria. The details were published some twelve years ago in the Detroit medical journals, and about two years ago were referred to by THE JOURNAL. The theory is a very simple and, I think, rational one, being an assumption that the remedies which cure the disease, will prevent its development in those who have been exposed to the contagion, and therefore to all who have been exposed, or are of the household, treatment similar to that for the diphtheritic patient is administered for from six to eight days; and, permit me to add that where the medicine was faithfully administered, I have yet to see the first case in which the disease was not confined to the original patient; and further, to show the severity of the tests to which the prophylaxis was subjected, several of those first taken died, in spite of all that I and the best counsel I could obtain, could do to save their lives. I may also mention that I have received a large number of letters from Maine to California and intermediate points, in which the writers, with very few exceptions, narrate experiences in that direction similar to my own. Notwithstanding these favorable results, I no not assert that the prevention will always be as complete as in the cases to which reference has been made, because those reported to me, or which have come under my own observation are too insignificant in number, compared with those of which I know nothing, to warrant a universal conclusion; but I think enough observation has been made, and with results sufficiently favorable, to warrant my asking for the plan a fair trial, as, if it shall prove trustworthy as a prophylactic, independent of the benefit to those who have been exposed, there are few households which cannot take exclusive care of *one* sick member, and hence, the risk from the spreading of the devastating disease will be reduced to the minimum.

Of the advantages of vaccination as a prophylactic, I do not now think it necessary to say anything. Years ago, when we were compelled to use

[1] Tiedeman gives the same proportionate weight of infant brain, but gives that of the adult at 1 to 36 instead of 46. From a somewhat extensive investigation of the subject while preparing my work on "Insanity," I am satisfied that his comparative relation is erroneous, as the average male brain is from 49 to 50 ounces; hence, at his proportion, the average weight of a man would be less than 112 pounds, and his height less than 5 feet.

humanized virus, and some times had to admit that syphilis and other diseases had been inoculated with the vaccine, I confess I had often grave doubts of the benefit, as a whole, of that method of preventing variola, but now that pure bovine virus can readily be obtained all doubts respecting the great boon conferred by Jenner have disappeared.

SYSTEMATIC INSTRUCTION IN COOKERY AS A BRANCH OF COMMON SCHOOL EDUCATION.[1]

BY GEORGE H. ROHÉ, M.D.,

PROFESSOR OF HYGIENE AND CLINICAL DERMATOLOGY, COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE, MD.

"The number of inhabitants who may be supported in any country, upon its internal produce, depends almost as much upon the state of the art of cookery as upon that of agriculture." (Count Rumford, Complete Works, vol. iv, p. 407.)

It is needless to call the attention of the members of this Section to the great importance of a sufficient supply of digestible and assimilable food for the maintenance of health. Physiologists have determined, both by experiment and empirically, that the different classes of food-stuffs—proteids, fats, and carbohydrates, with salts and water, must be consumed in definite proportions, if the individual's health shall be preserved. It is equally unnecessary to argue in favor of having all the various articles of food used by man of good quality and free from deleterious properties, because the sanitary conscience of every individual, no less than the physical reactions of the system, demand that healthy meat, fresh vegetables and pure water are food constituents absolutely requisite for perfect nutrition.

While, however, these propositions are accepted without dispute, it seems to be considered of minor importance how food is prepared before being taken into the stomach. Most persons, including, I am sorry to say, the large majority of physicians, are wofully ignorant of the chemistry of cookery. The changes that take place in food during its preparation for the table are not only imperfectly understood, but many physicians and nurses seem to consider it beneath their dignity to give the subject any serious thought. To say nothing of the almost universal ignorance of the culinary art, I merely call attention to the grave errors that prevail among the profession in regard to the nutritive value of meat essences, soups or teas, or of boiled meats. One hears much from quasi-professional and lay sources of the wholesome character of what is called "simple cookery." But, in the majority of instances, simple cookery means simply bad cooking. Frying, as the operation is usually done in this country, constitutes the basis of American simplicity in the culinary art, and all physicians are agreed that probably no other single factor is so prominent in the production of our national disease, dyspepsia, as this. I do not desire to be understood as condemning frying or any of the modifications of this process of cooking, when properly done. On the contrary, I think it is an excellent method of preparing meats, fish, and many vegetables for the table. But how rarely is the American frying-pan anything else than a utensil for slowly stewing an article in grease! Saturated and permeated with fat, the fried article of food becomes an indigestible mass, incapable of acting as an aliment.

The healthy common sense of many Americans, who have given thought to this matter, has led to the establishment of cooking schools in various cities, and in connection with some scholastic institutions, in this country. In a special report on "Industrial Education in the United States," issued by the Bureau of Education in 1883, reference is made to a number of schools of instruction in the culinary art. In Lasell Seminary, at Auburndale, Mass., cooking has been taught since 1877. In the same year, this branch of domestic economy received recognition in the Iowa Agricultural College, and the instruction seems to be very thorough, both on the theoretical and practical sides of the subject. A School of Domestic Science was also organized in the Illinois Industrial University in 1874, but the instruction in the chemistry of food and cooking seems to be largely didactic. At all events, the account of this institution in the report above referred to does not indicate that any practical instruction is given in cookery. Of cooking schools proper, I believe that of Miss Juliet Corson, known as the New York School of Cookery, was the first in this country. It was established in 1876, and has been the forerunner of a number of similar institutions in various cities. The Boston Cooking School was started about 1877, and conducted by Miss Parloa. In Baltimore, a wealthy gentleman, Mr. Chas. J. Baker, has given a handsome building especially constructed for a model cooking school. The institution was opened in 1884, but has unfortunately languished, apparently on account of lack of experience on the part of the board of management.

In Raleigh, N. C., Staunton, Va., and Washington, D. C., cooking schools have been put in successful operation. In this movement in the South, Miss Helen Campbell, a well-known writer upon social and domestic subjects, has been a prominent and successful worker. A private cooking school was in operation in Memphis in 1879. Cooking classes have also been formed under the auspices of the New Century Woman's Club, of Philadelphia. Practical and systematic instruction in cookery and other useful arts is given to young women of limited means.

The limitations of institutions dependent upon private support are, however, too contracted to permit the full development of this necessary reform. The absence of a sufficient number of paying pupils for a single term, may seriously cripple, if not entirely break up a private cooking school. This has happened in one instance known to the writer. In order to avert such insecurity, cooking should be made a part of the curriculum in the public schools. Time for the introduction of a new subject of such vital importance could be obtained by dropping some of the highly ornamental "studies" with which the cur-

[1] Read by Title in the Section on State Medicine, at the Thirty-Seventh Annual Meeting of the American Medical Association.

ricula of most of our girls' schools are crowded. "Mental philosophy," trigonometry and technical grammar could with very great advantage be replaced by practical instruction in household economy, and doubtless some time could also be gained for a little needed instruction in private and domestic hygiene.

This idea is not Utopian. In London, practical lessons in cooking are given in the girls' common schools. In this country the same thing has been carried into practical effect in the city of Boston. For several years volunteer efforts have been made by Mrs. Augustus Hemenway, of that city, to give instruction in cooking to a number of girls selected from the upper classes of the grammar schools. The results attained had a good effect upon the members of the school board, and for the present year cookery has been made a regular part of the curriculum in the girls' schools. This pioneer effort should be quickly followed in every municipality in the United States, and I would urge upon the members of the Section on State Medicine and Hygiene to endeavor to secure similar action in the States they represent.

139 N. Calvert Street, Baltimore.

TREATMENT OF PUERPERAL MASTITIS

By the External Use of Spirits of Turpentine.[1]

BY P. J. MURPHY, M.D.,

SURGEON IN CHARGE OF THE COLUMBIA HOSPITAL FOR WOMEN AND LYING-IN ASYLUM, WASHINGTON, D. C.

In the *Medical Record*, of July 31, 1885, page 123, appears the following article by Dr. Llewellyn Eliot, of this city: "About fifteen years ago I witnessed the beneficial effects of the free application of spirits of turpentine to abscesses and whitlows in their early stages. The result in each case in which such applications were employed was a drying up and disappearance of all traces of inflammatory or suppurative processes. From the earliest years of my professional life this has been a routine treatment with me, and arguing from analogy, it has been adopted in cases of mammary abscess when seen in its incipiency. The only disadvantage attending this treatment is the odor of the turpentine, which is of no importance when contrasted with the intense pain, sleepless nights, and suffering accompanying suppuration of the gland.

"If, upon the discovery of a drawing pain upon suckling, or a tender, hard spot in any part of the gland, the part be bathed with the spirits of turpentine, and then covered with a cloth, rag, or piece of flannel saturated with the same, we may, as a rule, look for the disappearance of the hardness, the tenderness, and all other uneasiness attending this troublesome affection, in the course of two, or at the most three days. During the course of such a treatment the child may be nursed from the affected breast, but not as frequently as from the well one. It is hardly necessary to say that all traces of turpentine should be washed away before such nursing. The amount of milk secreted has never appeared lessened in the cases observed, nor have any of the ill results of the continued use of turpentine followed either in the mother or in the child. Whether this manner of dealing with this affection be in general use or not cannot be said, still, there is no mention of it in many of the recent text-books on obstetrics.

"It is not claimed to be infallible, but its application will be attended with no bad results, even if it be unsuccessful. Strapping, pressure, rest, applications of belladonna and soap liniment, and the continuous application of an ice-bag, are among the various modes of treatment employed; but my faith now centres around the application of turpentine as an abortive of mammary abscess."

I had not seen mention made, in any of the text-books accessible to me, of the abortive treatment of mammary abscess by the external use of turpentine, nor could I find any authority recommending it as applicable in reducing inflammation of the mammary gland. I determined, therefore, to give it a fair trial, and place before you the result in thirteen cases in which the treatment was carried out. In the limited clinical experience I have had in the employment of turpentine as a local and external means of treating internal inflammations, none of the severe smarting and vesication of the skin has occurred, and in the cases I am about to recite, a general sense of comfort and relief was experienced from its application.

There is, of course, to be observed the same precaution in the use of this agent as in any other remedy—*excessive use is often an abuse.*

Case 1.—A. B. Child lived but a few hours. Breasts bandaged and became hard, some milk being secreted. Spirits of turpentine applied as a lotion and bandages left off. Milk secretion ceased and induration disappeared after a few applications.

Case 2.—A. P. Abortion at about six months. Some milk secreted on second day, and considerable induration accompanied it. Breasts bandaged and spirits of turpentine applied. Secretion of milk rapidly ceased and the induration as rapidly disappeared.

Case 3.—M. C. Breasts indurated, probably from over-secretion of milk. Spirits of turpentine applied a few times and hardness in breasts disappeared, and the super-lactation ceased.

Case 4.—M. L. Some induration of breasts, accompanied by marked over-secretion of milk. Spirits of turpentine applied three times, and induration passed away. The secretion of milk after this was of a proper quantity for child.

Case 5.—Alice G. Admitted twelve hours after delivery. The child had died. Some milk was secreted before admission, and considerable induration was present in the breasts. Spirits of turpentine applied twice daily for ten days, and secretion stopped. The induration ceased five days before.

Case 6.—L. L. Quantity of milk small; child did not nurse; breasts became hard. Spirits of turpentine applied for two days and the induration disappeared; the secretion of milk ceased.

Case 7.—S. W. Still-birth at eight months; some induration as secretion of milk began. Applications of turpentine made and induration passed away; the secretion of milk ceased.

[1] Read before the Medical Society of the District of Columbia, on November 3, 1886.

Case 8.—F. R. Still-birth. Breasts became indurated and spirits of turpentine was applied freely. Some milk was secreted after thirty-four hours. Turpentine continued and milk flow arrested in a few days.

Case 9.—F. J.—Child removed by friends after milk was secreted. Considerable induration and fever occurred. Two applications of turpentine per day for two days was made. Milk secretion, fever and induration stopped.

Case 10.—V. M. Child did not nurse. Breasts became indurated and considerable milk was secreted; four applications of spirits of turpentine were made in two days, and milk secretion ceased. Induration disappeared at the same time.

Case 11.—K. M. Breasts indurated directly after beginning of lactation. Three applications of spirits of turpentine dispersed the induration. In this case, and at the same time, her temperature ran up to 103° F., and stayed above 100° until the breasts were in a normal condition.

Case 12.—M. R.—The secretion of milk from both breasts was unusually plentiful and hard lumps appeared in both glands in a short time. Spirits of turpentine was applied four times. The induration rapidly disappeared and the supply of milk was considerably lessened.

Case 13.—J. H. Was nursing child up to day of entering hospital. Breasts very large and full of milk. Did not begin treatment with spirits of turpentine until second day. Applications were made three times a day for one week, and secretion of milk ceased. There was *at no time* any hardening of the breasts.

In *none* of the above cases were alteratives, as iodide of potassium, iodine, etc., used; nor were revulsives employed.

One clinical feature wherein I differ from the experience of Dr. Eliot is, that the application of turpentine either in part checks the mammary secretion or entirely arrests it. This is amply proven in the cases above cited. I do not mean to be dogmatical in this assertion, and merely call attention to this fact in order that the experience of others may lead us to form a just conclusion as to when and where we are to make use of this remedy, if at all.

You are all familiar with the various agents adopted in the prevention of mammary abscess. Most of them have been pointed out in the brief article by Dr. Eliot; some are eminently successful in certain cases and again fail, much to our chagrin. All of them have had a fair trial in my experience, with alternate failure where I expected success and success when I had little faith in their beneficial influence.

Then, again, cases yield very slowly to turpentine applications, the hardness and induration passing away very rapidly in some and persisting for weeks in others.

If this agent prove as efficacious as my experience guarantees in the preventive treatment of puerperal mastitis, the *bête noire* of the lying-in hospital will have vanished, and hundreds of suffering women be relieved from pain and agony. But this remains to be proved, and I bring the matter to the notice of the Society for this purpose, and to give Dr. Eliot due credit for calling attention to such a valuable remedy.

MEDICAL PROGRESS.

HOT WATER AS A HÆMOSTATIC IN OBSTETRIC AND GYNÆCOLOGICAL PRACTICE.—The value of hot water injections in menorrhagia was proved many years ago by Trousseau. and for their general use in the diseases of women we are indebted especially to Emmet. Parvin, in 1876, called attention to the use of hot water in arresting hæmorrhage from ruptured adhesions in ovariotomy. Courty first applied this agent as a hæmostatic in plastic operations upon the external genitals and the vagina. The late Albert H. Smith was one of the first, if not the first, to advocate intrauterine injections of hot water in the treatment of post-partum hæmorrhage. Yet it is probable that the value of hot water is not fully recognized by the profession, nor do all seem to know at what temperature the application should be made.

Within a few years one of the most distinguished of German obstetricians has asserted that relaxation of the blood-vessels was the remote consequence of hot water injections, though contraction occurred at first. A very useful and timely contribution to the subject has recently been made by R. MILNE MURRAY, in the *Edinburgh Medical Journal*. He studied, experimentally, the effects of water at different temperatures, and found that, at 110° to 120° Fahr., it constricts blood-vessels and arrests hæmorrhage from small arteries; at a temperature of from 60° to 100°, it dilates small vessels and promotes hæmorrhage; and at a temperature of from 30° to 50 it checks hæmorrhage by constricting the blood-vessels, but this only temporarily.

In regard to its therapeutic application in inflammations, Murray claims that it is evident that in water at 120° Fahr. we have an agent of immense power in controlling the local circulation in an organ, provided we can bring the water to bear directly on the part. Accordingly, a stream of hot water injected into the vagina cannot fail to affect, in a very direct way, the circulation in the uterus. The smaller blood-vessels will respond in such a manner that their calibre becomes narrowed under the stimulating effect, the abnormal blood supply will to a large extent, be cut off, and the resulting phenomena of inflammation checked.

Undoubtedly hot water vaginal injections are useful in some cases of pelvic inflammation, but to claim for this treatment constant success and constant applicability is, we think, an error. Patients are met with in whom great discomfort follows its employment, when it should be discontinued. In considering the use of hot water in obstetric practice, Murray divides the cases into those in which the contents of the uterus have not been discharged, and those of actual or threatened post-partum hæmorrhage, the placenta having been expelled. He states, in referring to the first class, that in all cases in which the abortion is inevitable, hæmorrhage going on, and the os dilating, he adopts hot water injections as a routine practice. He regards the agent as being most valuable in those cases in which hæmorrhage is ocurring or is imminent after the contents of the uterus

have been expelled, and that organ remains flabby and relaxed. Among the benefits claimed for hot water thus used are rapidity of action, duration of the tonus produced, and the absence of vascular reaction, and of exhaustion. This agent in the treatment of post-partum hæmorrhage certainly deserves all the commendation which it has received.—*Medical News*, December 4, 1886.

THE DANGER OF WOUNDING THE DIAPHRAGM IN OPERATIONS FOR EMPYEMA.—M. LAGRANGE says (*Archives Générales de Médecine*, Sept. 1886) that wounding of the diaphragm in operating for empyema is an accident the conditions of which it is necessary to know in order to avoid. He holds that it is a mistaken idea to suppose that the accident is rare, and cites cases in which it occurred when the seventh intercostal space was opened, and Kirmisson on one occasion found the diaphragm as high as the sixth intercostal space. This anomalous position of the diaphragm may be caused by adherence of that structure to the lung, with retraction of the lung or retraction of the parietes of the thorax, with consequent exaggeration of curve of the diaphragm; and it is a mistake to suppose, as is stated in the text-books, that pleural effusion is always accompanied by descent of the diaphragm. In many cases it is impossible to tell the exact position of the diaphragm, especially when it is intimately adherent to the thoracic walls. He advocates strongly that the operation of opening the pleura for the evacuation of pus should never be performed lower than the fifth intercostal space. Cases are recorded where the diaphragm has been wounded, and even the abdominal cavity opened and some of the contained viscera incised. At the Montreal General Hospital it has been the custom of late to open the pleural cavity low down, not uncommonly in the eighth and ninth spaces. I myself have frequently done this and without any untoward result. The diaphragm can always be felt through the incision. It is a good plan, and one which I have always adopted, after cutting through the tissues down to the pleura, to use a dressing forceps, if nothing but pleura intervenes it is easily perforated, and pus immediately exudes; but if diaphragm be present, the forceps cannot be pushed through it without the exercise of considerable force, and the condition may be recognized before harm is done. The value of a low opening is very great, because we thus thoroughly empty the pleural cavity and run no risk of leaving the narrow posterior portion filled with pus If the opening be made high up, this cavity cannot be thoroughly evacuated without washing out with some fluid, a proceeding which always complicates the operation, may introduce septic matter, and retards healing.—*Canada Med. and Surg. Journal*, December, 1886.

THE ACTION OF ANTIPYRINE.—There is an almost universal verdict that in antipyrine we have a most powerful antipyretic. That it is certain and quick in its action is generally conceded. There is no doubt that it is more certain and more rapid in its action than all agents of this class used up to the present time, with the exception of cold water. Occasionally, however, we notice reports of disagreeable and even dangerous untoward effects, where it has been administered to reduce an elevated temperature. Dr. Graham, of Brussels, reported a case last winter where alarming symptoms of collapse followed its administration to a typhoid patient. In the *British Medical Journal* for October 2d, 1886, Dr. Fairland reports a similar alarming state where it was given to a typhoid patient. The German medical periodicals of the current year contain a considerable number of reports pointing to a like action. The question naturally arises, Is it possible to obtain all the benefits of antipyrine and at the same time to avoid its untoward effects on the circulation? We believe this can be answered in the affirmative. Antipyrine can be given in such a way as to almost preclude the possibility of its acting as a cardiac depressant. It is simply a matter of dosage. The dose should *never* exceed 20 grains; doses of 30 grains and upwards are dangerous. When given in quantities of 10 grains and repeated every hour or two until the temperature reaches 101° F., the danger of collapse is practically *nil*. To give larger doses, or to reduce the temperature to below the normal even with less quantities, is not safe.

Many able physicians question the utility of any agent that simply acts as an antipyretic in febrile diseases. They contend that nothing is gained by simply reducing the temperature for a few hours. When the course of the disease is not in any way modified, how is the patient benefited? they ask. Are not the evils arising from the disturbance of the patient's nervous and digestive systems greater than the supposed gain we obtain by lowering the temperature? When we consider the direct pernicious influence that a continuous high temperature has on the nerve centres and muscular tissues, we believe we have quite sufficient justification for the use of those agents whose only effect is to reduce the temperature. The acute granular and fatty cardiac degeneration which is so frequently an active factor in the causation of deaths from typhoid fever and pneumonia, must surely be in some measure prevented or delayed by the judicious use of such an agent as antipyrine.—*Canada Med. and Surg. Jour.*, December, 1886.

ANALGESIC PROPERTIES OF SOLANINE.—Solanine belongs to the class of poisons which includes eserine, philocarpine, atropine, etc., the first physiological effect being to paralyze the nerve terminals of the non striated muscular fibres. There are, however, certain differences in the particular action of solanine which DR. GENEUIL proposes to utilize in medicine. The alkaloid may be prepared from the fresh seed of potato by means of boiling water slightly acidulated with sulphuric acid; ammonia is added to the hot decoction, precipitating solanine and phosphate of lime. The alkaloid is then dissolved out with alcohol and evaporated to crystallization. These crystals are insoluble in water, but slightly soluble in ether, readily so in hot alcohol. It is colored orange by

strong sulphuric acid, turning to deep violet and brown. With acids salts are formed. The hydrochlorate of solanine is obtained by dissolving solanine in alcohol, to which hydrochloric acid has been added, and precipitating the salt with ether. It forms a gelatinous body readily soluble in water. In doses of from 1 to 3 grains its action is confined to the medulla and cord, but in larger doses the cerebral cortex is also affected, the symptoms being vertigo, heaviness and noises in the ears. In poisonous doses there is violent headache, followed by delirium, cyanosis, and somnolence. Respiration is rendered deeper and slower, the pulse is not affected by the drug in medicinal doses. Its administration by the mouth in large doses is apt to give rise to nausea and vomiting with a desire to defæcate. In the stomach solamine is transformed into solanidine and glucose. Generally speaking the pupil is not dilated. Dr. Geneuil has found solanine of the greatest service in the treatment of sciatica and rheumatic neuralgia in doses of from 3 to 4 grains daily by the mouth or hypodermically. He has also used it in prurigo, cystitis, and in certain nervous affections where restlessness and insomnia were prominent symptoms. He has found it useful in acute dyspepsia and gastritis, lessening the pain and spasm, and good results have followed its administration in the obstinate vomiting of pregnancy. He recommends it strongly in the treatment of bronchitis, bronchial asthma, cardiac asthma, and emphysema. Solanine, he says may be prescribed without danger in large doses, and its use is not attended by the same inconveniences as morphine and atropine. It is particularly in lieu of the former that he finds it of service, especially in children.—*London Medical Record*, November 15, 1886.

RESECTION OF THE TARSAL BONES IN CLUB-FOOT.—In a paper read at the Fifteenth Congress of the German Society of Surgery, DR. KRAUSS, of Darmstadt, brought forward objections to those methods of treating club-foot, which consist in removal of portions of the skeleton of the foot, and in attempts to straighten the extremity by forcible manipulations. The author thus briefly states his views: 1. The different methods of resection of the tarsal bones impair more or less the form of the foot, the stability of its osseous arch, and the dependent mobility and usefulness of the extremity. On the other hand, a club-foot that has been successfully submitted to orthopædic treatment and tenotomy present a much-improved form, which, especially in young subjects, deviates very little, if at all, from that of the natural foot, and the usefulness of which will correspond with the innervation of its muscles. 2. Resection of the tarsus is not free from risk, whilst orthopædic treatment with tenotomy is quite safe. 3. Extirpation of the astragalus is a more suitable operation for restoring the form of the foot, than removing a wedge-shaped piece of the bones in the direction of the medio-tarsal joint, but it leaves an immovable or insufficiently movable ankle, a week union between the os calcis and the second row of tarsal bones, and serious shortening of the foot. 4. Resection of a portion of the tarsus spoils the skeleton of the foot to such an extent, that its performance removes almost all chance of a future restoration of the natural form of the extremity, and of its natural functions, by means of suitable orthopædic treatment. 5. There is no conceivable form of club-foot in which tarsal resection is justifiable, except it be in a case of one that is persistently painful in an old subject, and in which there is no prospect of good result from orthopædic treatment. In such a case resection might fairly be tried instead of amputation.—*London Medical Record*, October 15, 1886.

COFFINS IN THE CHURCH PORCH.—A correspondent calls attention to the practice, sanctioned by the clergy, of allowing the coffin to be brought into the church during the early part of the funeral service which takes place inside the church. In some parts of the year, this is not only offensive but even dangerous to those who sit by the decaying human tabernacle, and no possible good can result from it. The idea of bringing the corpse inside the church is, our correspondent points out, a superstition which came in about the fourth century, when the apostacy from the early faith began. The coffin, as is pointed out, might as easily be left in the porch. This is a matter to which attention may well be directed, and members of the profession would do well to endeavor to influence the clergy in favor of some change in respect to this ancient but unsanitary custom.—*British Medical Journal*, November 13, 1886.

TREATMENT OF SYPHILITIC CONDYLOMATA.—DR. A. G. PARSONS, of Durham, N. C., writes that he has tried the following ointment in many cases of syphilitic growths on the scrotum, and around the anus, and has never met with a failure:

℞ Morph. sulph. ..... gr. ij.
Pulv. camphor ..... gr. xx.
Bismuthi subnitrat.,
Hydrarg. chlor. mitis. ..... aa ʒ jss.
Cosmolin. ..... ʒj

Sig. Wash with soap and water, and then rub the ointment in twice a day. In a few days Dr. Parsons says, the warts will be found to have entirely disappeared.—*Medical Record*, November 13, 1886.

TREATMENT OF ORCHITIS AND EPIDIDYMITIS.—MR. LOWNDES describes the treatment adopted at the Liverpool Lock Hospital for cases of orchitis and epididymitis. The affected testicle is painted with a solution of nitrate of silver (two drachms to the ounce), at the same time strict rest in bed is enforced, and the inflamed organ is supported upon a small pillow. When the patient is compelled to go about his ordinary work, the painting of nitrate of silver tends to cure the case more rapidly, but it does not get well so quickly as those that take complete rest in bed. [In 1868 Mr. Jordan cured cases in twenty-four hours.]—*London Medical Record*, October 15, 1886.

THE
Journal of the American Medical Association.
PUBLISHED WEEKLY.

THE EDITOR OF THIS JOURNAL would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the writer's full name and address, although not necessarily to be published. All communications in regard to editorial work should be addressed to the Editor.

SUBSCRIPTION PRICE, INCLUDING POSTAGE.

PER ANNUM, IN ADVANCE.....$5.00
SINGLE COPIES.....10 CENTS.

Subscriptions may begin at any time. The safest mode of remittance is by bank check or postal money order, drawn to the order of the undersigned. When neither is accessible, remittances may be made at the risk of the publishers, by forwarding in REGISTERED letters.

Address
JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION,
No. 65 RANDOLPH STREET,
CHICAGO, ILLINOIS.

SATURDAY, DECEMBER 18, 1886.

DRUMINE—THE NEW LOCAL ANÆSTHETIC.

The characteristics and properties of the Euphorbiaceæ are so multiple and so different, that it is scarcely a matter of surprise to learn that one of the order has now been shown to yield an anæsthetic. DR. JOHN REID, of Port Germein, South Australia, has recently obtained a local anæsthetic from Euphorbia Drummondii, and this drug, for want of a more convenient term, he calls *Drumine*, until chemists give a better name. In his experiments he used the hydrochlorate, *Drumini chloridum*, very soluble in water, and obtained in the following manner: A tincture is made with rectified spirit (though he believes proof spirit would answer, especially if acidulated with hydrochloric acid). After standing a few days it is evaporated to get rid of the spirit, ammonia is added in excess, and the solution filtered. The residue, after the ammonia smell is gone, is dissolved in dilute hydrochloric acid, and the filtrate is filtered through animal charcoal to destroy the abundant coloring matter, which is inactive medicinally, but causes a bluish tinge of the skin. The filtrate is evaporated slowly, and leaves the alkaloid. It gives a colorless solution with little taste, almost insoluble in ether, freely soluble in chloroform and water, and depositing from solutions microscopic colorless acicular and stellate crystals, the latter being more numerous in the deposit from aqueous solutions. Roughly speaking the length of the crystals is about one to twenty diameters of a white blood corpuscle (or from 4 to 260 mmm.). Those deposited from hydrochloric acid solution, are filtered through animal charcoal, are circular or boat-shaped at the circumference, and stellate, or perhaps more correctly, discs, as if formed of concentric circles, and with radiating or other fissures. Under high power the acicular crystals are sometimes of a rhomboid shape, and seem less soluble in chloroform; from which it may be suspected that there are two alkaloids, though Dr. Reid was unable to investigate this point.

Dr. Schomburg, of the Adelaide Botanical Gardens, who determined the species of the plant for Dr. Reid, states that many sheep and cattle are annually killed by eating it, and that it is more poisonous according to the quantity of milky juice which it contains. It is said that animals die within twenty-four hours to seven days after eating it, all being paralyzed in the extremities, and some hanging the head as though intoxicated, though the appetite does not seem to be impaired. It is also said that yellow eyes, and even jaundice, occur in some cases. Its most remarkable and valuable effect, however, is that of causing local anæsthesia. When a few drops of a watery solution, estimated at 4 per cent., was dropped into the eye of a cat, the eye was found in a few minutes to be tolerant of contact with the finger, and the orbicularis muscle did not contract firmly as did the other. The pupil was not appreciable dilated. Three grains injected subcutaneously into the back had no other apparent effect than local anæsthesia. When Dr. Reid applied it to his tongue, nostrils and hand very marked anæsthesia was produced; even the sense of taste for quinine was abolished on the side of the tongue to which it was applied. Small doses taken internally seemed to produce no constitutional effects. In a case of sciatica in an old man, in which he had tried iodide of potassium and ammonia, the first hypodermatic injection of 4 minims of a 4 per cent. solution, enabled him to stand and walk in a short time with comparative ease, the pain having disappeared. A second injection, on the following day, acted as well, and at the time of writing the report the pain had not returned. Dr. Reid used it for cases of sprain, and the "speedy effect is probably sufficient to allow us to bid farewell to evaporating and lead lotions. I have seen it work like magic in a boy, (boil?) the dose being the same, and injected over the adductors of the thigh. For tic I have dropped it into the eye and applied locally with success."

In regard to the physiological action of drumine: "Where death arose from an overdose of the drug, paralysis of the extremities occurred. . . and we may suppose that the posterior cornua of the cord (sensation) are primarily affected, the poison passing to contiguous parts. I am very much inclined to be-

lieve that reported cases of paralysis are neither more nor less than cases in which movements remain, but the sense relations with the external world exist to a very limited extent, while motion is still possible. . . It will be seen that strychnia, as an antidote, affects only the motor parts, while there is *possibly an antagonism* to a slight extent between chloroform and the drug. . . There seems to be no special action on the pupil, although the cornea is insensitive by local application. In no case have convulsions followed its use. To sum up: cocaine seems to have a mixed action, sensory and motor, to cause preliminary excitement—Drumine is almost a pure sensory (no action on the pupil) paralyzer, without preliminary excitement; can be given with comparatively slight, if any, risk. A fungus is generated in the drug solution after some days. Its uses may be summed up as follows: Nerve troubles of a painful character, not due to a constantly exciting cause which remains potent, operations, irritation, œdema, sprains and such like; but I believe there is a brilliant future for this drug in the domain of cerebral physiology on account of its almost purely topical action. For hydrophobia, and croup with spasms, it would be used fearlessly and applied either to the nostril, by spray, or with a very fine hypodermic needle into the larynx. Those daring spirits who inject antiseptics, *e. g.*, corrosive sublimate to the phthisical lung, will probably, in this drug, find a valuable adjunct. Let us hope, from its causing no preliminary excitement, it may be useful in peritoneal and bowel ailments of a painful nature, whether by hypodermic needle or by the mouth. Writer's cramp and its congeners appear to indicate its use." In cases of poisoning by it Dr. Reid would recommend Epsom or Glauber's salts alone, or combined with tartar emetic in small doses, with plenty of fresh food, in order to eliminate it and act antidotally.

Of course the correct interpretation of facts, on untrodden ground, with a limited supply of a drug, and without such apparatus for manufacture and experimentation as would be desired, is very difficult; and certainly no one would be inclined to quarrel with Dr. Reid for not telling us more about *Drumine*—on the other hand, the world is his debtor, especially that portion of the medical world which is in the habit of making annual addresses, and which has been ringing the changes on cocaine for two years. Let us hope that, so long as they have no new facts to present, they will at least give part of their attention to *Drumine*. Dr. Reid's interesting paper may be found in the *Australasian Medical Gazette*, of October 15, 1886.

THE GENERAL MEDICAL COUNCIL OF GREAT BRITAIN.

This body, as is generally known, has the supervision of medical education and registration of those legally qualified to practice in the United Kingdom, and until the present time it has been composed of representatives appointed by the Crown, the Universities, and the Corporations or Royal Colleges of Physicians and Surgeons. By an amendment to the medical laws, adopted by Parliament in the early part of the present year, provision was made for the addition of five members to the General Council, to be chosen or elected by the profession at large. The object was to give the whole body of registered members of the profession, and especially the general practitioners, a voice in the General Medical Council. As might have been expected, many candidates were announced either by themselves or their friends, and a very general interest developed in the election. Three of the new members were to be elected in England, one in Scotland, and one in Ireland. The results of the election show that fourteen candidates were voted for in England, three in Scotland, and two in Ireland. Of the fourteen candidates voted for in England Dr. Claudius Galen Wheelhouse, of Leeds, received 8,548 votes; Sir B. Walter Foster, of Birmingham, 7,718 votes; and Dr. James Gray Glover, of London, 6,619 votes. The next two highest on the list were Dr. B. W. Richardson, of London, 4,705, and Dr. Thomas M. Dolan, of Halifax, 3,063; while the votes for the remaining nine candidates ranged from 1,223 down to 214. Of the three voted for in Scotland Dr. William Bruce, of Dingwall, received 661 votes, being a plurality of 51 over the next highest candidate. In Ireland Dr. George Kidd, of Dublin, received 1,212 votes, it being 287 majority over his only competitor. A large majority of the candidates were general practitioners, and those elected are to be regarded as pledged to represent the real interests of this important part of the profession.

AN ANATOMY ACT NEEDED IN MARYLAND.

Recent dispatches from Baltimore state that a most horrible murder was committed on December 10 for the purpose of securing the body of an old woman for the dissecting room of the University of Maryland. The fact that there had been foul play was discovered by Dr. Herbert Harlan, the Demonstrator of Anatomy, and it is thought that the negro janitor is implicated. The details of the affair have no medical interest, and need not be described. The fact that in this day the dissecting room of a medical

college, situated in a large city, or anywhere, should be dependent upon grave-robbers is, however, worthy of comment; to say nothing of the possibility for crime afforded by such dependency. It is not difficult to make a Legislature see that human bodies are necessary for medical colleges, or to get them to pass laws which will bring dissecting material to the colleges without the possibilities of grave-robbing or crime. At present enlightened, and even uneducated, people can be easily made to see that dissection is a necessary part of a medical education. But the practice of receiving bodies torn from the grave is one that brings the profession into a certain amount of disrespect, or disrepute, even among people whose sensibilities are not extraordinarily fine. It is about time that the medical profession of Maryland, and other States which have no anatomy acts, should exert themselves to the utmost in order to have proper provision made for supplying their medical colleges with dissecting material.

DIED.—At Pasadena, Cal., December 4, 1886, Edith Cole Scott, wife of Dr. X. C. Scott, of Cleveland, Ohio, in the 30th year of her age.

SOCIETY PROCEEDINGS.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Stated Meeting, November 3, 1886.

THE PRESIDENT, C. H. A. KLEINSCHMIDT, M.D., IN THE CHAIR.

(*Concluded from page 669.*)

DR. P. J. MURPHY read a paper on

THE TREATMENT OF PUERPERAL MASTITIS BY THE EXTERNAL APPLICATION OF SPIRITS OF TURPENTINE.

(See page 683.)

DR. L. ELLIOT said: The report which Dr. Murphy has just read, I have heard with much pleasure and satisfaction, as this method of treatment has been the one I have followed for some years, and, so far as I know, had not been reported previous to the appearance of my paper. We all know the pain and suffering attending these abscesses, and the fear with which women allow their incision. In the treatment of threatened mammary abscess, I have tried the application of ice, belladonna, tight strapping and iodine, as well as the internal administration of calcium sulphide; and have at times prevented suppuration.

About sixteen years ago I saw spirits of turpentine applied to an abscess on the neck, on account of the excessive pain experienced, and, strange to say, after the burning had passed away, the surface became hardened and no further trouble followed. In 1879 and 1880, it was my fortune to meet with several cases of mammary abscess, all of which went to suppuration, one reaching such a state that it more resembled a cancer; free incisions with and without, drainage with horse-hair, ice-bags, supports of all kinds, strapping so tight that the pressure was painful, belladonna and camphorated soap liniment were tried, but with no good result. After this experience, the idea of the spirits of turpentine recurred to me, and in the next case it was tried with the result of seeing all inflammatory symptoms pass away in three days. The manner of its application, which I published in the *Medical Record* for July 31, 1886, is simple, and does not interfere with the employment of other measures.

The breast is bathed well with turpentine, then dried, a piece of soft cotton or flannel wrung out of turpentine is applied and allowed to remain on for a short time, possibly half an hour. This is to be repeated three or four times a day. After each application the breast is to be washed well before nursing the child. It has never been necessary to stop nursing the infant from the affected breast.

I believe if women would pay more attention to the premonitory symptoms of this trouble, seeking advice as soon as they feel a drawing pain upon suckling, and find a hard, tender spot in the breast, abscesses of this structure would be much rarer than they now are. Following this plan of treatment I have had to open but three breasts in forty cases of threatened abscess. No strangury or other unpleasant symptoms have occurred from absorption of turpentine, either in the mother or the child.

DR. S. C. BUSEY said he thought the title of Dr. Murphy's paper slightly misleading, as he does not believe that after pus has formed turpentine would effect a cure so rapidly. After reading Dr. Elliot's paper (in the *Record*, July 3, 1885,) he had determined to use turpentine when occasion offered. On October 24, last he had been called to see a lady who was nursing a ten-months old infant. The lady had had, the night before, a chill, followed by fever and sweating. She was just recovering from a second one when he saw her. Her temperature was 102.5°. She had also had pain in the right breast for several days, and that gland he found swollen, red and very painful. She had attributed this to her corsets. He could not get fluctuation, but his diagnosis was threatened mammary abscess. He ordered quinia and turpentine to the breast. If turpentine irritated it was to be diluted with oil until bearable. The next day the patient had no fever or pain in the breast, and in forty-eight hours she was well. This was a case of mastitis following injury, and was consequently more significant than some of Dr. Murphy's cases. He was, however, certain that no pus was there and that the chills were a coincident affection.

In all his long experience he had never found any method so satisfactory as this, and so far as one case goes he testifies to the efficacy of turpentine as abortifacient of threatening suppurative inflammation.

A year later the lady had a similar attack. Turpentine was used but was not successful in dissipating inflammation. There was, however, no suppuration.

Mammary abscess, however, is a comparatively rare affection. It occurs most frequently in primapara, and usually follows a fissured nipple. He thought that physicians should treat promptly all fissures or abrasions upon the breast, and in this way prevent a possible abscess.

DR. C. E. HAGNER said he had had no experience in mastitis, but he agreed with Dr. Busey in the importance of prophylactic measures against abscess. He thought it important to keep the breast from becoming engorged. It ought to be properly supported as soon as milk appears, and after that kept nearly empty. He did not think it rational or according to our knowledge of pathology to suppose that any drug should be so accommodating as to pass through the skin, reach the lacteal ducts, and abort an inflammation, without getting into the milk in the ducts, as was affirmed. Warmth and moisture to relax engorged vessels were necessary in inflammation. For these, and in addition counter-irritation, turpentine might do. Cold or some hæmostatic, as ergot, might do in first stage of inflammation, but beyond that stage he did not believe abortion possible.

DR. S. C. BUSEY said that he thought Dr. Hagner a little "out" in his ideas of the pathology of mammary abscess. There were three forms. The most common was the superficial, in the subcutaneous tissue; then there was the parenchymatous and the submammary. Turpentine put on the skin does not get beyond the subcutaneous tissue, which is absorptive tissue; hence the parenchyma of the gland is not affected. Dr. Hagner says that an hæmostatic may be of use. Turpentine is an hæmostatic, though he cannot say how it acts. Dr. Hagner also says that he has never used turpentine, but when he has used it as many as thirteen times perhaps he will think better of it. If we exclude drugs whose method of action we are not familiar with, we will have to shorten our list considerably. Thus the method of action of most of the drugs we use externally is unknown.

DR. HAGNER replied that he was not referring in his previous remarks to the submammary and rare forms of abscess, but to the two commoner forms. In the thirteen cases reported by Dr. Murphy it was by no means certain that pus was going to form. Surely no pus was present in any of them so far as he could see. In fact, some were reported cured of mammary abscess before the usual time for abscess to appear under the circumstances. As for the frequency of this affection, in seventeen years of practice he had had but one case of mammary abscess.

DR. T. C. SMITH asked how the irritation and vesication usual with turpentine on a delicate skin was prevented?

DR. P. J. MURPHY replied that at the first symptom of too severe an irritation the drug was removed or the parts smeared with ointment or oil.

GYNÆCOLOGICAL SOCIETY OF BOSTON.

Stated Meeting, October 14, 1886.

THE PRESIDENT, H. O. MARCY, M.D., IN THE CHAIR.
H. J. HARRIMAN, M.D., SECRETARY.

DR. E. W. CUSHING presented a mass of

HYPERTROPHIC RECURRENT GLANDULAR TISSUE REMOVED FROM THE FUNDUS UTERI.

This mass of atheromatous tissue filled a four-ounce measure and was recurrent the fourth time. Dr. Cushing called attention to the practical malignity of such growths.

He also exhibited an

OVARIAN CYST

which was interesting from the fact that it had been diagnosed as a pregnancy by a practitioner of eminence. The tumor was multilocular, and it was with difficulty extracted through a small opening. Dr. Cushing asserted that, in spite of Mr. Lawson Tait's success in operating with an incision of two inches, it was bad surgery to remove a tumor through an opening too small for comfort, and that a large incision, if aseptic, would heal as readily as a small one.

DR. W. SYMINGTON BROWN read a paper entitled

THE RÔLE OF THE OVARY.

The writer criticised the study of pathology to the exclusion of normal physiological processes. Pathological minutiæ were compared to the scaffolding about a house during its erection. It serves a practical purpose, but becomes useless after the completion of the building and must be removed, else it will mar the beauty of the structure. More is to be learned by careful observation of natural processes and guarded deductions therefrom, than from the twisted facts which disease presents. For similar reasons the writer attached but little importance to vivisection as a means of discovery. Experiments on living animals may corroborate or test a great disclosure, but seldom or never find one out. The changes which the ovary undergoes each month may be called the cycles of involution and evolution. When the latter attains its maximum the ovary becomes nearly twice as large as at the close of involution. The ovary is a gland which secretes free cells. It maintains an intimate connection with many other glands—a relationship more marked during pregnancy, but also noticeable during menstruation. Various glandular diseases, such as jaundice, albumenuria, salivation and mastodynia, may all be dependent on or connected with changes in the ovary. The more rapid recovery of robust women than delicate ladies from puerperal diseases is attributed to the greater activity of the glandular system in the former class of patients.

The theories of Dr. Noeggerath of New York, in regard to the widespread and pernicious influence of latent gonorrhœa upon the tubes and ovaries, producing sterility, were referred to with approval. The fact that prostitutes so seldom conceive is without doubt due to salpingitis and periuterine inflammation arising from gonorrhœa. This sterility is also often

found in virtuous women whose husbands are the subjects of a latent gleet and have communicated it to their wives. The fibrous ovarian sheath becomes thickened; the Fallopian tubes are filled with mucopus, or closed, and it is highly probable that the ova themselves never become developed. If both sides are thus affected, sterility is a foregone conclusion.

The removal of the ovaries for metrorrhagia, salpingitis, long-continued agonizing pain or intractable pelvic disease, was discussed. Dr. Brown maintained that the common objection to these operations, that they unsex the patient, was baseless. Sex is not lodged in either ovary or testicle; if it be in one part more than another it is in the brain. A long series of observations had convinced the writer that insanity in women often depends on sexual disorders, and that such cases can only be cured by local treatment. In severe cases of hystero-epilepsy, Battey's operation is conceded by the most conservative to be justifiable.

Reference was made to a class of cases where sterility follows a sudden arrest of menstruation. Whether this unfortunate event is due to the closure of the fimbriated extremity of the Fallopian tubes by a low-grade inflammation, or to arrest of development of ova due to nervous shock, is uncertain.

In considering the question of cases in which menstruation persists after removal of the uterine appendages, attention was called to the possible existence of a third ovary or of single ovisacs in the human parovarium. Where menstruation persists for some months after such operations, it is probably due to the persistence of the original menstrual impetus. Ovariotomy has proven that the sex of the fœtus does not depend upon the particular ovary which furnishes the germ. The determination of sex probably does not depend upon anything done by either party, but occurs long prior to conception in either the ovary or testicle.

Dr. E. W. Cushing wished to thank Dr. Brown for his excellent paper. He agreed with him in regard to the importance of gonorrhœa as an agent in producing disease of the uterine appendages. These results may follow from an old gleet when for years there has been no discharge at the meatus. In many cases the latent gleet can only be diagnosticated by a microscopical examination of the secretions of the urinary tract. In all cases the *gonococcus* can be found. Dr. Cushing expressed the opinion that nine-tenths of the inflammatory troubles peculiar to women arise from the clap.

Dr. L. F. Warner did not believe that a slight gleet often caused ovaritis, metritis, or many of the other diseases so often attributed to gonorrhœa. He did not believe that Noeggerath's views upon that point had ever been generally accepted by the profession.

STATE MEDICINE.

SANITARY CONVENTION AT BIG RAPIDS, MICHIGAN.

A Sanitary Convention, under the auspices of the Michigan State Board of Health, was held November 18 and 19, 1886. It was opened by an address of welcome by the Mayor of the city, E. W. Hudnutt, Esq. Dr. John Avery, of Greenville, Mich., President of the State Board of Health, spoke in response to the address of welcome, and said that the object of the Convention was not to benefit physicians, but the public. The members of the State Board of Health also wished to gain information, that they may better serve the people.

Dr. John P. Stoddard, of Muskegon, read a paper on

INJURIES OF EVERY-DAY DRUG-TAKING.

He said the habit of taking drugs and nostrums was beyond comprehension. It partly came from mothers dosing babies with soothing syrup, hive syrup, paregoric, worm lozenges, etc. Druggists and proprietary medicine companies distributed flaming bills, chromos and free samples of nostrums from house to house. The prevention was to educate the people in the injurious effects of drugs. There should be less medicine taken, and only on the advice of a physician after a careful diagnosis. A doctor was not capable of prescribing for himself when ill, much less the laity, who knew nothing of the action of drugs.

Dr. David Inglis, of Detroit, read a paper entitled

ALCOHOL: WHAT EFFECT HAS IT AS FOOD, MEDICINE OR POISON?

In closing his remarks on alcohol as a medicine, he said: I should like to produce the continually accumulating evidence of the positive harm caused by such indiscriminate use of all kinds of alcoholic drinks, bitters and tonics. I should like, even more carefully, to define the conditions in which alcohol ought to be used than I have here done. I have only time to urge that we ought, in all cases, to let alcoholic liquors be the last, and not the first, remedy; that we ought to give alcohol in definite and known doses, and only during such time as the drug is required, and to make it our business to see that its use is then suspended, just as we do in case of opium.

Dr. J. L. Burkhart of Big Rapids, read a paper on the *Water-Supply of Big Rapids*, which embodied the report of the committee appointed by the common council to investigate the matter of procuring a better article of water for that city, and contained much of special interest to the citizens of Big Rapids.

Prof. W. N. Ferris, of the Big Rapids Industrial School, read a paper on

HYGIENE OF SCHOOLS.

He said that he could not recall ever having visited a room regularly occupied by forty or fifty pupils, that could be said to be properly ventilated. Dulness, nervousness, headache, colds, catarrh and consumption are among the frequent effects of staying in such rooms. Under the influence of bad air, study is irksome, good behavior difficult, and the play-ground a heaven. He dwelt upon the lack of ventilation in the Big Rapids schools; and said that the foul-air openings could be made several times

larger with slight expense. Strange as it may seem, school patrons think very little about ventilation, and care less. Their sleeping and sitting rooms are without any intentional means of ventilation. Vitiated air is the most expensive commodity which man takes into his body; for in thousands of families the expenditure of money for a single year which sickness and loss of time occasion by inhaling poison would defray the necessary expenses for properly ventilating a decently constructed house. In several of the school rooms of Big Rapids, the air space for each pupil does not exceed 200 cubic feet. We should construct rooms for lower grades very large, and use single desks. The speaker denounced the style of desks in use in one school-room in Big Rapids as "torture appliances."

JUDGE M. BROWN, of Big Rapids, read a paper on

PUBLIC HEALTH LAWS.

After referring to the health regulations of the ancients, he said: As civilization has advanced, and the average of mankind has reached a higher condition upon the plane of intelligence, health laws have become more general and better enforced. It may be stated as a fact that the race of man has advanced mentally and physically in proportion as heed has been given to the laws for the promotion of health. A kind of intuition seems to pervade the human race, aside from and above all law, that it is necessary to care for the public health in order to be comfortable and happy, and to enjoy this life. This intuition has probably led to the enactment of health laws by persons and bodies having legislative authority. Some offenses against the public health are punishable by the common law—by fine and imprisonment—such as the selling of unwholesome provisions. When articles of food are sold for domestic purposes, the law implies a warranty that they are fit for such purposes. The supreme court of this State says that this rule is not only reasonable, but essential to public safety. He then discussed English sanitary work. He thought the laws of Michigan in regard to public health were good enough, but the way they are usually enforced is very bad. Perhaps one of the greatest sources of sickness in our midst is the want of proper ventilation in buildings occupied as dwellings, public halls and other public places where large assemblages of people convene. In this county, until a very recent date, at every term of the circuit court more or less people in attendance became sick. Court was held in a room entirely unfit for occupancy on account of not being properly ventilated. . . . . I desire to call attention to the subject of prisons and jails in this part of the State. I don't know a jail within the ninth congressional district that is properly ventilated, and hardly one that is proper for a human being to remain in over night. This subject has been agitated and investigated by the State Board of Health and the State Board of Correction and Charities, and a great deal of valuable work has been done; but there is still very much to do.

SURFACE FILTH AS A MEDIUM OF DISEASE

was the subject of a paper by REV. HENRY A. WALES, of Big Rapids. He said: In 1876, Dr. Henry Bowditch, of Boston, made an estimate of the annual cost to the people of the United States because of unnecessary sickness, and placed the figures at $100,000,000. Later, one of our own physicians—who is with us to-day—revised the estimate, going more into detail, and he increased the amount to $300,000,000; a loss each year of over $10,000,000 to the people of Michigan. And this estimate leaves out of view the physical suffering, the mental pain and anguish, and the death of loved ones around our social circles. In regard to filth he said: By surface filth we mean anything of this disgusting nature that is thrown upon or is suffered to lie upon the surface of the ground around our habitations or places of business—garbage, or the refuse of vegetable and animal matter; dirty water of every description, from that in which food is cleansed, to the dish-water and slops of a household; dirt swept from the floors of the home or shop; the contents of the wood-box and spittoons; the refuse of wood-yard, hen-house or pig-pen; and the excrement from chambers and privies. Besides these, there are sources of filth in musty rooms, woolen blankets, feather-beds, and the cellars under the house. Rubbish of any kind always becomes filthy if allowed to stand; and dampness increases filth by causing fermentation and vegetable growth. A close inspection of all the premises of a habitation is continuously needed, that nothing which may cause filth shall be allowed to accumulate. Mr. Wales thought that the "grand march of the giant contagion begins in the surface filth and the vaults of the civilized privy;" and he thought that if the dry earth system was universally introduced, it would exterminate such diseases as cholera, dysentery, and typhoid fever, as they are propagated solely by germs in the voided excrement.

DR. JNO. AVERY, of Greenville, President of the State Board of Health, read a paper on *Pasteur and Protective Medicine.*

FOREIGN CORRESPONDENCE

LETTER FROM LONDON.

(FROM OUR OWN CORRESPONDENT.)

Economy of Cremation—Bequest to Cambridge University—Paraplegia in Pott's Disease—Solution of Tannin for Ingrowing Toe-nail.

Mr. W. Eassie, who is Honorary Secretary of the Cremation Society of England, in a paper on *The Economy of Cremation*, shows that our present system of interment is very costly. At a low estimate the cost of the metropolitan cemeteries was taken at £272,000. Assuming cremation to be practised and to become the mode of disposing of the dead by even 50 per cent. of the population of London, a piece of ground of about 500 acres in extent would be sufficient. It shows, too, that £75,000 would amply cover the expense of the cremating area, and in addition, Mr. Eassie remarked that on

the same basis of calculation some 605 acres of ground would be saved from pollution by the dead. Furthermore, the 500 acres set apart for cremation purposes would serve a population of two and a half millions for 1000 years. The cost of funerals in England and Wales alone in 1874 amounted to £4,871,000. On a fair estimate the cost of cremating 3,100 bodies in 310 working days would only amount to some 10s. 6d. each. The facts and figures introduce in a very plain fashion a question of vast public interest. They involve considerations connected in a more than intimate fashion with the public health, and they afforded food for thought to all who are disposed to discuss a matter, which in its bearings on our physical welfare assumes a high rank. The subject of cremation is, of course, one which it is neither desirable nor possible to force into public prominence. But it is eminently one which demands the quiet and earnest consideration of all thinking people. There are in the question of the proper disposal of the dead many points of sentimental nature, which possess their due influence in modifying opinions, and in raising objections to so-called innovations. The practice of ordinary burial has been so long the way of the tomb, that any departure from this method of disposing of the dead must needs, for a time at least, be regarded with feelings approaching to impatience if not to absolute repugnance.

The most important of all the objections to the present system is the danger to health. Burial grounds, especially around London, tend to become crowded, and the condition of some cemeteries is a crying disgrace to civilization. Coffins piled one on top of the other, and separated by only a few inches of earth, present a spectacle which, while it affords a powerful argument for cremation, must also rudely shock the supporters of the method of ordinary burial. It is a known fact of science that the germs of many infectious diseases are not destroyed by prolonged burial in the earth. Pasteur's experiments on the vitality of the bacilli of splenic fever in cattle have proved this much. Hence, in times of plague and epidemic we only perpetuate by ordinary burial the danger of fresh infection of the living. Add to this the danger of pollution of water supply and of the air itself, and one can readily allow that the advocates of cremation are by no means supporting a foolish project for selfish ends when they advise the incineration of the body in preference to its long and slow decay in the ground.

At the Sanitary Congress at York, the supporters of which are known as "reformed funeral" took part in a discussion on cremation. The leading idea of this reformed method is the quick mingling of human dust with the earth. But it is obvious that one fatal objection remains to all such methods of disposal of the dead. That a body may be resolved sooner or later into its elements in the ground, and that the earth may act as a natural disinfectant, it is absolutely necessary to have a soil of a particular kind. The ground of many cemeteries, so far from disposing readily and quickly of bodies buried therein, actually leads to preserve them. The horrors of clay cemeteries, for example, which are essentially waterlogged plats of ground can scarcely be overdrawn, and unless therefore one could invariably pick and choose our burial-grounds, it would appear that the "earth to earth" earth system is put out of court. In many localities it would be impossible to find the necessary kind of soil, therefore cremation alone is left as an unobjectionable means of decently disposing of the dead, with a due regard to the health of the living. Crematoria now exist at Woking which silently and quickly reduce a human body to a condition of dust, such as would take many years to produce under burial even in the most favorable soil. It must also be noted that the real end of burial and of cremation is practically and chemically the same. It is the disintegration of the body into its elements. Burial accomplishes this slowly and often very imperfectly, cremation produces this quickly and without danger to the living. The public is apt to associate the process of cremation with flames and funeral pyres, and the real facts of the case require to be made widely known. Did the public but know that there is no exposure of the dead, no infringement of decency or respect, and no spectacle calculated to hurt the feelings of the mourners, cremation would be more common than at present.

By the will of the late Mr. John Lucas Walker the University of Cambridge receives the munificent bequest of £10,000 "for the promotion without regard to sect or party, of scientific and literary research or of either of these objects, in Cambridge, or in the metropolis or in either of these places." After careful consultation the Vice-Chancellor, Professor Huxley, Sir James Paget and several others, have determined to establish the "John Lucas Walker Studentship," and its administration to be entrusted to the Professor of Pathology in Cambridge University, and a board of management consisting of the Cambridge Regius Professor of Medicine and Professor of Physiology, and the President of the Royal College of Physicians. The income to be applied: 1. To endow a studentship, to be called the "John Lucas Walker Studentship" of the annual value of £200, or such larger sum as the managers may determine, not exceeding £300, tenable for three years, the holder of which shall devote himself to original research in pathology. 2. To further original research in pathology, by additional studentships or exhibitions, prizes or grants at Cambridge or in London. It is stipulated that the studentships, exhibitions, or prizes may be held by and awarded to persons of either sex. It is also expressly set forth that the studentship shall not be awarded as the result of a competitive examination, but the students are to be elected on the nomination of the Professor of Pathology.

At the Harveian Society of London, Dr. Huhlings Jackson remarked on the great length of time during which a patient might remain paraplegic in cases of Pott's disease of the spine and yet recover, sometimes as long as twelve months. He trusted to rest in bed, and put no faith in drugs or applications to the spine, as he had fully made up his mind that they had no beneficial effect upon the spinal cord disease.

At the meeting Dr. Huhlings Jackson showed a boy of 12, recovering from a second attack of paraplegia associated with Pott's disease of the spine. The only treatment had been rest, and he considered the prognosis in such cases was invariably good when complete rest was enforced.

The application of a concentrated solution of tannin to an ingrowing toe-nail is highly spoken of, as it is said if applied with a camel's-hair brush to the soft parts twice a day, to quickly lessen the pain, and after a few dressings it is stated the patient is able to move about with comfort. The strength used is 6 drachms of water and an ounce of tannic acid.

G. O. M.

DOMESTIC CORRESPONDENCE

LETTER FROM NEW YORK.

(FROM OUR OWN CORRESPONDENT.)

Phthisical Lung Injected with Iodine—Intubation for Laryngeal Diphtheria.

At the first December meeting of the New York Academy of Medicine, Dr. J. Blake White presented a very interesting specimen of a *Phthisical Lung Injected with Carbolized Iodine*. In his remarks upon it he said that the results which he had met with during the past year the local treatment of diseased lungs had very greatly excited his enthusiasm. Theoretically, intra-pulmonary medication seemed to be a very rational therapeutical method, and practically he had found it to be of much efficacy. He mentioned particularly a case of his in which it was followed by recovery; the progress of the patient being watched with interest by three medical friends. The preparation which he prefers for injections is a mixture of carbolic acid and tincture of iodine, to which a small quantity of morphia and atropia is added. In the cases in which he has employed it all the symptoms have been relieved; the cough being controlled, expectoration diminished, sleep improved, and night sweats checked.

The specimen presented was the left lung of a patient in whose case, although hopeless as regards cure at the time the first injection was made, the effect of the treatment was very marked and gratifying. He was a milkman, 46 years of age, and Dr. White gave a somewhat detailed history of the case. When first seen by him last summer at Charity Hospital, he was in the third stage of phthisis, with a large cavity in the upper part of the left lung, which was in a state of active suppuration. There was profuse expectoration, exhausting night sweats, and all the ordinary symptoms of advanced pulmonary tuberculosis. On the 19th of July the first injection of ten minims of carbolized iodine was made in the first intercostal space. It was followed by no reaction, and there was immediate and marked improvement in the patient's condition. The following week a second injection, of the same character and quantity, was given, and this also, without any reaction whatever, was followed by a great improvement in all the symptoms.

On August 30 a third injection was made; this time twenty-five minims of the carbolized iodine being administered. It was attended by a brief paroxysm of coughing, but no bad results followed, and marked improvement was subsequently noted in the symptoms, as before. Dr. White's term of service at the hospital now expired, and no more injections were made. The patient died October 19, and at the autopsy both the left lung and the pericardium were found involved in the most extensive pleuritic adhesions. In the vicinity of the cavity at the apex of the lung a considerable space was seen to be tinged by the injections. The upper portions, where the injections had been made, presented a marked contrast to the lower portions, where the tissues were in a state of advanced disintegration. During life also the auscultatory signs had indicated a dry condition of the upper parts very different from that met with in the lower. But very little pus was found in the cavity.

The principal paper of the evening, by Dr. Wm. P. Northrup, was on *Laryngeal Diphtheria and its Treatment by Intubation*. Had Bouchut, he said, only been a little more prudent and temperate in controversy with Trousseau in 1858, it would have been France, and not America, which would have had the honor of successfully introducing this now widely accepted method of treatment. As it was, however, the Paris Academy of Medicine announced its deliberate opinion that intubation of the larynx was impracticable, and no more was heard of it for nearly thirty years, when it was revived by a Fellow of the New York Academy of Medicine, Dr. Joseph O'Dwyer, in a manner which soon attracted the attention of the entire profession. All of Bouchut's severe cases, it was true, terminated fatally; but the fact remained that the stenosis had been relieved, and it was also incontestably shown that the larynx would tolerate a tube. These were the data upon which O'Dwyer's successful achievement was based.

Dr. Northrup then proceeded to give the statistics of all the cases of death from laryngeal diphtheria which had occurred among the children of the New York Foundling Asylum during the past five years. He did not make any distinction between croup and diphtheria of the larynx; all the fatal cases of the former being apparently included in the deaths from laryngeal diphtheria. The number of children connected with the institution is about 1800 per annum; of which 1100 are cared for by paid nurses in their own homes, and the remainder accommodated in the asylum buildings. There were 87 deaths in all from this cause; of which 50 were in females and 37 in males; and the greatest mortality was found to be between the ages of three and four years. In 56 the membranes began to form in the larynx before or simultaneously with the exudations in the pharynx. In two cases croup was the first symptom, and death occurred within twenty hours. In 54 cases there was pneumonia, and broncho-pneumonia was very frequently met with. Twenty-seven children died from extension of the membranes into the bronchi, and in 29 the pneumonia was sufficiently severe to cause death alone. In 19 the highest temperature

noted was 104°, in 15, 105°, in three, 106°, in two 103°, and in one, 107°. In all but three of the 87 cases the extent of the membranes was very marked. Interstitial emphysema occurred in eight cases. There were 51 cases of primary diphtheria, and 31 in which the disease was nearly or remotely related to scarlatina or measles.

Dr. Northrup exhibited a set of O'Dwyer's instruments for intubation, and explained the method of introducing and extracting the tube. It was better, he said, to make several short attempts to introduce it than one prolonged effort, on account of the interference with respiration thus caused. The extraction of the tube is more difficult than its introduction, and at the suggestion of Dr. O'Dwyer he recommended that physicians should practice both introduction and extraction upon the cadaver. Those beginning to practice intubation, he continued, were apt to use too small a tube, with the result that it was coughed up. Care should be taken, therefore, always to select the size of tube suitable for the age of the child, as indicated by the scale accompanying each set of instruments. There was, however, no danger of the tube slipping down into the trachea, as some seemed to fear, since the head of the smallest tube could not pass the cricoid cartilage, where the narrowest point of the passage is situated. Neither was there any danger of ulceration of the vocal cords being caused by the tube.

If the condition of the child continued encouraging for forty-eight hours after the insertion of the tube, Dr. Northrup thought that a favorable prognosis might be given; but that it was entirely unsafe to make such a prognosis at any period before the expiration of the forty-eight hours. Not infrequently the greatest possible relief was temporarily secured by intubation in cases which afterwards terminated fatally by the extension of the membranes downwards or by the occurrence of pneumonia. He also spoke a word of caution in regard to withdrawing the tube too soon. Whether it would be advisable to reintroduce the latter in any case would depend on the condition indicated by an examination of the chest. If, on auscultation, the vesicular murmur was normal, there was no cause for uneasiness; but if it was found that the air could not get well into the lungs, especially the posterior portions, it was time to reintroduce the tube. The condition of the pulse also served as a valuable guide to the experienced.

Having mentioned that O'Dwyer's tubes were of good service in stenosis of the larynx in adults, and especially when the condition was due to syphilis, he announced some general conclusions, among which were the following: Intubation relieves dyspnœa due to laryngeal stenosis, and is open to few objections. It is comparatively simple and is also free from danger. No anæsthetic is required, nor is there need of a trained assistant. There is no fresh wound to serve as a new focus for infection. If intubation proves inefficacious, tracheotomy can still be performed. Intubation, however, he said, had one conspicuous fault, viz.: that it embarrasses and sometimes interferes with deglutition. There is also one danger connected with it: the tube might possibly push some of the tenacious membrane down before it, and thus cause a blocking up of the trachea below.

Did it meet the requirements? he asked. The statistics undoubtedly showed that it did. Waxham had had 96 cases, and O'Dwyer 48; and in the 165 cases which had thus far been reported, no less than 28½ per cent. had been saved. It was to be remembered, too, that the method was still new. Valuable experience had been gained, and it could scarcely be doubted that in the future the results would be even more favorable. The statistics of tracheotomy showed no such satisfactory result as this, and Dr. Northrup believed that if all the fatal cases of the operation were reported, the percentage of mortality would be considerably larger than it now appeared.

In the discussion which followed the reading of the paper, Dr. Francis Huber stated that he had practised intubation in eleven cases. The special conditions which led him to resort to it were aphonia, stridulous expiration, and extreme recession of the chest walls, above and below the sternum. He gave a brief sketch of each of his cases, and then said that out of the eleven there had been four recoveries, while one child was still wearing the tube. Five had died, and one other, in which he had just practised intubation, would probably also prove fatal. These results were much better than he had obtained with tracheotomy, which he had performed twelve times, but had succeeded in saving only two out of the twelve children. He stated, also, that in all his cases of iutubation the method was resorted to very late. In conclusion, he exhibited a modification of the O'Dwyer gag devised by his friend, Dr. Denhard, who had also had eleven cases of intubation. Five of them were successful, and all of the eleven, like his own, were late cases.

Dr. A. S. Hunter related two cases, both seen in consultation, in which he had practised intubation. The first was that of a child 6 years of age who had been suffering from membranous croup for two days. The stenosis was extreme, and pulmonary œdema was coming on. He introduced the tube with little difficulty, and the relief was immediate and very marked. After forty-eight hours, however, he saw the patient again, and found the respiration very rapid. It had great difficulty in walking, and he found that by trying it with a considerable quantity of nourishment at a time it did better than if the attempt was made to feed it by the teaspoonful. The pulmonary trouble was now so great that it was evident that the child could live but a few hours longer. He therefore removed the tube, and found that it breathed well without it. Death occurred about seven hours afterward. The second case was in a child 2½ years old with diphtheria, who had a temperature of 103.5°. There was marked stenosis of the larynx, and it was almost completely asphyxiated. The relief afforded by intubation, as in the other case, was prompt and satisfactory. The next day, however, the child coughed up the tube, and it was reintroduced by the attending physician; but death ensued in five or six hours later. Dr. Hunter stated that he had practised intubation five or six times on the cadaver before he attempted it on the living subject.

Dr. Partridge said that Dr. Northrup had mentioned that the only danger from intubation was the possible detachment of portions of membrane which might act as a diaphragm in the trachea below the tube. The same objection held true, however, in regard to tracheotomy; and he referred to a case of this operation in which fatal obstruction occurred in the manner described.

On the evening of December 3, the first meeting of the Section on Public Health, Hygiene and Legal Medicine was held; when Dr. Blaine, of the Willard Asylum at Ovid, N. Y., read a paper on "Bovine Tuberculosis; Its Communication by Inhalation, Ingestion and Hereditary Transmission, and its Dangers to Public Health." P. B. P.

PENETRATING WOUNDS OF THE ABDOMEN.

TO THE EDITOR OF THE JOURNAL:

Dear Sir:—I notice by the report of the discussion which followed the reading of Dr. H. H. Smith's paper on "Penetrating Wounds of the Abdomen," read in the Section on Surgery, at the thirty-seventh annual meeting of the Association, as given in your issue of November 27, I am credited with remarks which do not clearly represent my position or views upon the important subject which was presented. Most likely, at the time of the discussion, I was not distinctly heard by the Secretary; or else the necessity to condense prevented him reporting me as fully as I should have desired.

What I did say in substance was this: That although I *had been credited* with the honor of having been the first to open the abdomen to search for perforated gunshot wounds of the intestine, *where there had been no protrusion*, and to apply sutures to the intestinal wounds, yet I was by no means disposed to urge this practice as the best under all circumstances. On this account I would mention my two published cases. The first of these was the one in which the operation was done for artificial anus following a bullet wound received some weeks previously. There had been no intestinal protrusion. I opened the abdomen, freed the wounded intestine from its many adhesions, resected the same, thus restoring the continuity of the gut, by suturing together the freshened surfaces (See *Amer. Jour. of the Med. Sciences*, July, 1867; also 2d vol. "Surgical History of the War").

In the other case, the abdomen was opened for a recent pistol wound of abdomen without protrusion (See *Transactions of South Carolina Medical Association*, 1882; also *Medical News*, May 13, 1882). Here I exposed and sutured five perforations of the small intestines, and two of the mesentery, but failed to discover, as shown by the post-mortem, one additional intestinal wound. I mention this case because of the turn this discussion has taken. It is a fixed idea with many that where there are perforations of the intestines there must be fæcal extravasation. No such extravasation was found at the autopsy, although, as said, I had failed to suture one of the perforations of the gut. And yet there had occurred diffusive peritonitis and death. So, then, the argument that there must be fæcal extravasation, which will lead on to a fatal termination if there be no immediate operation, cannot always be sustained. I am, from my report of these early cases, upon record as an advocate for immediate operation by abdominal section in wounds of the character described; and I still hold to this view, while admitting that those who advocate a different practice have some reason to sustain them.

Dr. Gregory, who has been most earnest in condemnation of the immediate operation, has spoken very wisely and judiciously in some regard. But I cannot accept one of the propositions as announced by him, viz.: that traumatic inflammation is always a limited process. This is not true, and such a doctrine cannot be used as an argument to induce us to remain passive where the intestines have probably been perforated. Traumatic inflammation, as I know to my cost, often extends rapidly. Practically it matters not whether such extension be caused by *sepsis* or not. I remember many years ago, forcing down by the finger in the rectum, a small sessile fibroma of the uterus, and causing it to encroach upon the posterior vaginal wall. Then I cut open the small tumor and twisted it off in a second. My patient died in a few days of diffusive peritonitis. Was not this an extension of a traumatic inflammation? The same result can as readily, or more readily, follow a perforated bullet wound of the intestine. Are we, then, not warranted in trying to prevent such a calamity by an early abdominal section? Respectfully,

R. A. KINLOCH, M.D.

285 Meeting St., Charleston, Dec. 8, 1886.

ABUSE OF MEDICAL CHARITIES.

TO THE EDITOR OF THE JOURNAL:

Dear Sir:—The editorial in THE JOURNAL for November 27 suggests one point in connection with Dispensary service for neglect of which the profession is blamable. The principles inculcated in the Code of Ethics, Sec. 3, Art. 1 ("duties of the profession to the public"), are most praiseworthy, but it would be well to define them by adding "in the absence of provision for that purpose, or in cases of sudden emergency." In every centre of population exists a large body of the impecunious. This comprises first, those whose means are small, or whose employment is irreular and income uncertain; and second, the habitual pauper and the habitual "dead-beat." Honest, legitimate poverty deserves the sympathy and assistance of every right minded man, and in most cases can command it. In this country such a condition is, as a rule, temporary or due to passing causes, and with these unfortunates any regular ethical practitioner can accommodate circumstances to cases without violating the spirit of his fee bill. It is in dealing with the habitual pauper and the habitual dead-beat, that the profession does itself grave injustice, and tends to still further demoralize this class. Practically they only exist in towns containing some thousands of inhabitants, and when resident for any

length of time become well known. Their demands upon the practitioner are arbitrary, arrogant, and unceasing; while the general testimony is that they are more troublesome and unreasonable than good paying patients. It is from their ranks that the unwarrantable but none the less harrassing actions for malpractice arise; and they furnish the majority of the litigants in damage cases against corporations and private individuals of means.

The point I wish to urge is that the profession should in practice be more discriminating; where means of relief have been provided by the local authority, they should unhesitatingly refuse applications for services from these classes, and where attendance has been accidental or involuntary it should be immediately discontinued.

It tends still further to demoralize, where medical men allow bills to be contracted by persons having no means and very rarely any intention of liquidating them.

Indirectly the druggists as a body suffer from similar causes, as their bills for prescriptions compounded are impossible to collect. That a young practitioner will occasionally meet a case which possesses sufficient interest or rarity to repay him, is not to be gainsaid, but the instances are few and far between. On the other hand, the dignity of the profession is lowered, its motives misinterpreted, and good intentions brought into disrepute by this element, which sneers at the eagerness of physicians for business, boasts that it can obtain the services of "any doctor in town," and is ever importunate, ungrateful and vindictive. Yours truly,

JAMES H. PARKINSON, L.R.C.S.,
City Physician, Sacramento, Cal.

NECROLOGY.

JAMES T. MEEK, M.D.

Dr. James T. Meek was born in York Co., S. C., in 1842, and died in Ennis, Texas, November 11, 1886, aged 44 years. He was educated at the Kings Mountain Military Institute, graduating in 1859. He at once began the study of medicine under the direction of Drs. Lindsley and Jackson, of Yorkville, S. C., and attended his first course of lectures in 1859–60 at the South Carolina Medical College. On the breaking out of hostilities between the States, he laid aside his studies and shouldered a musket as a private soldier in the 5th S. C. Regiment (Confederate). The authorities soon found that he could be much more serviceable in the medical department than in the ranks, and he was accordingly transfered to the former. Notwithstanding the fact that he was already relieved from the position of a private soldier, he persisted in retaining his former post during the first battle of Manassas, in which his nerve and undoubted courage won him the approbation of his comrades, both officers and men.

Dr. Meek graduated in medicine at the Virginia Medical College, Richmond, Va., during the session of 1862–3. Soon after his graduation in medicine he passed a most successful examination before the Board of Army and Naval Medical Examiners (C.S.A.), and was at once given the rank of assistant surgeon in the army, and assigned to duty in the Winder Hospital, Richmond, Va., where he soon, by his studious habits, gentlemanly bearing and the successful practice of his profession, won distinction and honor. He continued in the medical service of the Confederacy till the final collapse, filling various positions of trust both in the field and hospital, and laying up precious stores of clinical experience, both in medicine and surgery, upon which he was able to draw in after years with honor to himself, and of untold advantage to his patients and medical friends.

The war being over he located in Johnsville, Bradley Co., Ark., in the summer of 1865, where he at once entered on a large and lucrative practice. His work in this field was immense, and far too trying for his physical strength. After six years of arduous labor at Johnsville (during which he contracted the malady, which finally proved fatal), he moved to Ennis, Texas, where he resided till the time of his death. In this new field, as elsewhere, he soon made many warm friends among the profession as well as the laity, and to the very last was honored with the business and confidence of a numerous and respectable clientèle. He was a man of most noble traits of character, and of sterling worth, firm and decided in his opinions, yet kind and courteous in his intercourse with others, and especially so towards his professional brethren. As a man he loved truth, loved honor, and could be trusted and confided in under all circumstances. As a physician he was conscientious, conservative, able, and his practice both in medicine and surgery was eminently successful. He took a deep interest in medical societies, and was a member at the time of his death of the American Medical Association, the Texas State Medical Association, and the Ellis County Medical Society.

BOOK REVIEWS.

A MANUAL OF MIDWIFERY. By ALFRED LEWIS GALABIN, M.A., M.D., F.R.C.S. (Lond.), Obstetric Physician and Lecturer on Midwifery and the Diseases of Women to Guy's Hospital, etc. Illustrated with 227 wood engravings. 8vo., pp. xxxii–753. Philadelphia: P. Blakiston, Son & Co. 1886. Chicago: W. T. Keener.

The first thing to be noticed in opening this book is that the author has, and wisely some may think, omitted a general description of the anatomy of the female sexual organs, or of the development of the embryo, for the very good reason that students are supposed to be familiar with this subject before beginning the study of midwifery. He has only given so much of the anatomy of the pelvis as has a direct bearing upon the subject of the book. With the exception of some points the teaching of the book agrees with that given by most obstetrical authorities. Among the exceptions may be mentioned the choice

of leg to seize in version for shoulder presentation, the application of a noose to the prolapsed arm, the use of the vectis in protracted labor with an unreduced occipito-posterior position of the vertex, and the use of an oscillatory movement in forceps extraction. In regard to the choice of the leg to be seized in transverse presentations, Dr. Galabin's teaching is practically the same as that given by Lusk, and opposed to that of Simpson, who held that the facility of version depended upon seizing the leg of the *opposite* side of the body to the presenting shoulder. The author's teaching with regard to the application of a noose to the prolapsed arm has also been followed in this country, and in the *American Journal of Obstetrics*, vol. ix, p. 203, may be found the account of an ingenious method which Dr. F. P. Foster employed for making use of the prolapsed arm as an aid to version.

Dr. Galabin uses the vectis in the following manner in occipito-posterior positions: "When labor is arrested or protracted and the occiput fails to rotate forward, rotation may be effected either by a force actually directing the occiput forward, or by one which causes flexion, since it is through defect in flexion that the inclined plane of soft parts fails to turn the occiput forward as usual. Both these indications are fulfilled by the use of the vectis. If the vectis is applied over the occiput and traction made toward the vaginal outlet, as much forward as possible, first, flexion is promoted by the descent of the occiput, and, secondly, the occiput is directly drawn forward, since the vaginal outlet is directed forward in reference to the direction of the pelvic axis at the point where the centre of the head is lying. . . . Even when called in to perform craniotomy, after vigorous efforts to extract with forceps had failed, I have found that the occiput could be turned forward by the vectis with surprising ease, and that then extraction with the forceps presented no difficulty whatever." Without Dr. Galabin's direct statement it would scarcely seem probable that delivery could not be effected with the forceps alone with the complication mentioned; but in other than skilful hands it seems that the vectis is less capable of causing injury to the maternal soft parts, as it is used as a lever, the left hand, pushed up as high as possible, being the point of lever-resistance, and not the pelvic wall.

The gain which can be obtained by oscillatory movements of the forceps, says Dr. Galabin, is due solely to the amount of friction which can be reversed; and this movement is only admissible in those cases in which friction is an important obstacle to advance. And even in these cases he thinks that it is best avoided if direct traction can effect the object sought. "When, however, the head is engaged in the pelvic canal, and impacted in it by friction so that it cannot be readily pushed back in the interval of a pain, and when moderate traction fails to cause any advance of the head, oscillatory movement of the handles may be cautiously tried before recourse is had to craniotomy. The oscillation should be limited in degree, and with each oscillation should be combined firm compression of the handles, so as to make the head one solid mass with the blades, and the maximum of traction which it is thought safe to exert. The oscillation, to be of service, should be in that diameter in which the head is most tightly gripped by the pelvis. Thus, in a flattened pelvis it should be backward and forward, and in a uniformly contracted pelvis it may be in both directions, or the two may be combined in a limited circular movement. . . . The oscillatory movement should not be persevered with long unless the head is found to advance with it, for, if the leverage is successfully called into play, there must be an advance at each oscillation."

There are other points of special interest in this book on which we would gladly touch did space allow. We can only say that one cannot be otherwise than pleased with the work. It is well written; and both author and publishers have reason to congratulate themselves upon its value and appearance.

OUTLINES OF THE PATHOLOGY AND TREATMENT OF SYPHILIS AND ALLIED VENEREAL DISEASES. By HERMANN VON ZEISSL, M.D., Late Professor at the Imperial-Royal University of Vienna. Second Edition, revised by MAXIMILIAN VON ZEISSL, M.D., Privat-docent for Diseases of the Skin and Syphilis, at the Imperial-Royal University of Vienna. Authorized edition. Translated, with Notes, by H. RAPHAEL, M.D., etc., New York, 8vo., pp. xii, 402. New York: D. Appleton & Co. 1886. Chicago: A. C. McClurg & Co.

The most needle-eyed critic, except he be a unicist, can find nothing to carp at in this book, which is a summary of the life-work of one of the, if not the, most eminent syphilographer that ever lived. Added to this, the book has been translated by one who is sufficiently a master of both English and German as to have given us a good translation, singularly free from the round-about expressions too frequently seen in works translated from the German. Those who know anything of the methods of the late Professor von Zeissl need not be told that all his work and investigations were carried out with conscientious scientific exactness and thoroughness, and that while wedded to pathology he was never divorced from good therapeutics. It is rarely, indeed, that one can find a work in which pathology and therapeutics are so happily combined as that neither seems to have been given more consideration than the other. We would more especially recommend the work to some of our dermatological friends (a few of whom reside in England) who have a *penchant* for finding new syphilitic lesions, and for giving them incomprehensible and startling names.

HOW WE TREAT WOUNDS TO-DAY. A Treatise on the Subject of Antiseptic Surgery which can be understood by Beginners. By ROBERT T. MORRIS, M.D., Late House Surgeon to Bellevue Hospital; Consulting Surgeon to the Woman's Hospital of Brooklyn, etc. Second edition, pp. x, 164. New York: G. P. Putnam's Sons. 1886.

The first fault which a reviewer has to find with this book is that it is not indexed: this is a grave

fault in any book, however small it may be. But on careful search one must admit that this is the only fault that can be found in this very complete résumé of the antiseptic treatment of wounds. The author has a style which seems to be all his own, and for a larger and more pretentious work would be thought undignified; but it is a style which impresses facts upon the reader; and after all that is one great factor in making a book useful. No one who reads this book carefully and with understanding can afterwards feel that any of his time was wasted. Dr. Morris not only tells his readers how to dress wounds, and with what, but he tells them where the materials can be bought, how much they will cost, and how they should be prepared. The subject is presented to the readers as though it were something entirely new—and this is just what should have been done.

SURGICAL DISEASES OF THE KIDNEY. By HENRY MORRIS, M.A., M.B., F.R.C.S., Surgeon to and Lecturer on Surgery at the Middlesex Hospital, London. 12mo., 555 pages, with 6 chromo-lithographic plates and 40 engravings. Cloth, $2.25. Philadelphia: Lea Brothers & Co., 1886. Chicago: A. C. McClurg & Co.

Ten or fifteen years ago, before surgeons handled the kidney so freely as at the present day, this book might have been considered a useless addition to surgical literature. But since we have learned so much about these organs, and have found out that there is much more to be learned, such a book, from a surgeon who commands as much respect as does Mr. Henry Morris, cannot be otherwise than favorably received. It is especially to be noted that the work is introduced by a few pages on the regional anatomy of the kidney. The directions for the various operations on the kidneys are given clearly and concisely.

ECONOMY OF COAL IN HOUSE FIRES; or how to convert an ordinary Fire Grate into a slow combustion Stove at a Small Cost. By T. PRIDGIN TEALE, M.A., F.R.C.S., Surgeon to the General Infirmary at Leeds. Illustrated. Pamphlet, cloth, pp. 47, 10 plates.

A DISCOURSE ON THE PRINCIPLES OF DOMESTIC FIREPLACE CONSTRUCTION. By T. PRIDGIN TEALE, delivered at the Royal Institution on February 5, 1886. Pp. 30, bound with above. Leeds: Goodall and Suddick. London: J. & A. Churchill. 1886.

The article on "Economy of Coal in House Fires" is an expansion of a lecture delivered in 1882, and is now "published in the hope that it may contribute to the diminution of the soot and smoke throughout the Kingdom, and so further one great aim of sanitary reformers, the improvement of the atmosphere of towns; that it may effect a large reduction in the amount of cinders and ashes, and so lessen municipal rates; that it may enhance the comfort of the sick room by rendering a fire more free from noise and dust and more lasting; and that it may induce many persons, including the delicate, the invalid, and the hardworked family doctor, to look upon a fire in the bedroom, not as a superfluous extravagance, but as a much needed comfort, nay, as a profitable investment towards the maintenance of health." Surely such objects are worthy of all respect, and in no place should they be more appreciated, outside of England, than in Chicago.

It does not require a very great amount of knowledge or intelligence to follow the plain statements and directions of Mr. Teale in regard to fireplace construction and economy of fuel, and the illlustrations are good enough to enable one to easily understand what is shown. In another department there will soon appear a more general discussion of Mr. Teale's work.

THE SURGICAL DISEASES OF CHILDREN. By EDMUND OWEN, M.B., F.R.C.S., Surgeon to the Hospital for Sick Children, Great Ormond Street, London. 12mo., 585 pages, with 4 chromo-lithographic plates and 85 engravings. Cloth, $2. Philadelphia: Lea Brothers & Co. Chicago: A. C. McClurg & Co.

This volume may be called a "complete monograph" in a series of clinical manuals, rather than an attempt at an exhaustive treatise. It is not as its title implies, strictly limited to the surgical affections of children, but this does not render it the less valuable. The whole book is well written, is well indexed, and is a valuable addition to a valuable series of clinical manuals.

AMERICAN MEDICAL ASSOCIATION.

FORMED IN 1846.

Next annual meeting will be held June 7th, 8th, 9th, and 10th, 1887, in Chicago, Ill. President, E. H. Gregory, M.D., St. Louis, Mo. Permanent Secretary, W. B. Atkinson, M.D., Philadelphia, Penn. Assistant Secretary, J. Nevins Hyde, M.D., Chicago, Ill. Treasurer, Richard J. Dunglison, M.D., Philadelphia, Penn. Librarian, C. H. A. Kleinschmidt, M.D., Washington, D. C. Chairman of Committee of Arrangements, Charles Gilman Smith, M.D., Chicago, Ill.

All membership dues should be sent direct to the Treasurer, RICHARD J. DUNGLISON, M.D., lock box 1274, Philadelphia, Penn.

MISCELLANEOUS.

NEW YORK STATE MEDICAL ASSOCIATION, FIFTH DISTRICT BRANCH.—The next meeting of the Fifth District Branch will be the third *annual meeting*, to be held in Brooklyn, on Tuesday, May 24, 1887. There will be a morning and an afternoon session. All Fellows are solicited to contribute to the meeting, either by reading papers, notes or communications, or by exhibiting specimens. All papers offered

are the property of the Branch, and in future will be published in a current Medical Journal. The Secretary desires to be notified of the title of any paper to be offered as early, as convenient.

E. H. SQUIBB, M.D., *Secretary.*

P. O. Box 94, Brooklyn.

TYPHOID FROM A SINGLE DOSE.—M. Dujardin-Beaumetz has forwarded to the Paris Academy of Sciences a communication on the Pierrefonds typhoid cases last summer. M. Fernet, who occupies a high post at the Ministry of Public Instruction, his wife and family, hired a house at Pierrefonds, a fashionable resort near Compiégne, contiguous to two others. After they had rented it for the season they were told to beware of the water in the well. On this account they drank exclusively mineral water until the last day, when the stock was out, and the servants were too busy preparing to return to Paris to go and fetch some bottles from the chemist. Madame Fernet said, "For once surely there can be no harm in drinking the well-water." They drank it. Six out of the nine persons have since died, including one of the servants. The cook, two of the four children, and Madame Fernet had had typhoid fever before, and though attacked again by it after their return from Pierrefonds, have got through the illness. The well has been examined and is reported to contain the bacilli which are believed to be associated with typhoid fever. This is a common danger to which visitors to so-called health resorts, both on the continent and at home, are frequently subjected. The facility with which well-water is infected is hidden from the population by the impunity with which filthy well-water may often be drunk by resident families who have become acclimatised, especially when that water is for the moment infected only by non-poisonous fæcal matter, and this fancied immunity often leads to habits of carelessness, for which not themselves only, but their visitors have to suffer.—*British Medical Journal*, Nov. 27, 1886.

SANITARY INSPECTORS.—In a paper on this subject, read before the New Jersey State Sanitary Association on Nov. 19, DR. HENRY MITCHELL said: The inspector should so thoroughly know every part of every building in his district; its surroundings, its construction, its lighting, heating, ventilation, water supply and drainage, that he can almost certainly anticipate just how preventable disease may be produced on a given premises. He should be able to tell how it can happen, for instance, that typhoid fever could appear; whether the water supply, the cellar, the door-yard or the drainage is in fault, and whether an adjoining premises has probably caused the mischief; and whether the case was probably imported from another locality. He should know the vital statistics of every dwelling, and be thus aided in judging of the probability of the existence about a premises of some unknown source of danger to health. He should know the condition of every vacant lot, street, and public place in his district.

All of this valuable information should be carefully and regularly recorded and classified, so that it may be available for daily study. Is it probable that these various facts can be carried in memory in a clear and useful form? And if death or removal from office deprives a locality of its inspector, shall the accumulated information which years, perhaps, may have been expended in gathering, be lost? Such a sanitary history should be on the files of every local board of health, and its story should be familiar to every member of such a board. Such a record is worthy of the greatest care in its preparation. Entries should be made with ink, and nothing vague or indefinite should mar its pages.—*Sanitary News*, Dec. 11, 1886.

WOMAN'S MEDICAL COLLEGE OF CINCINNATI.—The first Session will begin on February 16, 1887, with full Faculty and ample facilities. The Dean is Dr. D. D. Bramble, 165 Broadway, Cincinnati.

OHIO STATE SANITARY ASSOCIATION.—The fourth annual meeting of this Association will be held at Columbus, O., on the second Thursday and Friday of February, 1887.

DR. R. HARVEY REED, of Mansfield, O., recently gave "A Sanitary Talk for the Farmer" before a farmer's institute held in Mansfield. Such meetings afford excellent opportunity for the sanitarian to sow sanitary seed, and the *Sanitary News* suggests that State Boards of Health coöperate with agricultural boards so as to be heard at the regular meetings.

DR. OWEN T. HUNT, of La Crosse, Ark., died on September 22, from the effects of a gunshot wound. He was born in Tennessee in 1833, and was graduated from the University of Pennsylvania in 1854.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM DECEMBER 4, 1886, TO DECEMBER 10, 1886.

Major A. A. Woodhull, Surgeon, ordered for duty at post of Ft. Leavenworth, Kans. S. O. 138, Dept. Mo., Dec. 3, 1886.

Capt. F. C. Ainsworth, Asst. Surgeon, will repair to this city and report in person to the Secretary of War, and on completion of the duty which may be required of him will return to his station (New York City). S. O. 280, A. G. O., Dec. 3, 1886.

Capt. Fred. C. Ainsworth, Asst. Surgeon, relieved from duty as Recorder of the Army Medical Examining Board, New York City, and ordered to report in person to the Surgeon-General of the Army for duty in his office. S. O. 282, A. G. O., Dec. 6, 1886.

Capt. P. R. Brown, Asst. Surgeon, leave of absence for seven days, granted by Post Order, is extended twenty-three days. S. O. 124, Dept. Ariz., Nov. 24, 1886.

Capt. H. S. Turrill, Asst. Surgeon, ordered for duty as Post Surgeon, Ft. Spokane, W. T. S. O. 207, Dept. Columbia, Nov. 29, 1886.

Capt. Edward C. Carter, Asst. Surgeon, leave of absence extended six months. S. O. 281, A. G. O., Dec. 4, 1886.

First Lieut. Paul Clendenin, Asst. Surgeon, assigned to duty at Ft. Davis, Tex. S. O. 166, Dept. Texas, Nov. 29, 1886.

OFFICIAL LIST OF CHANGES IN THE MEDICAL CORPS OF THE U. S. NAVY, DURING THE WEEK ENDING DECEMBER 11, 1886.

Percy, H. T., P. A. Surgeon, U. S. N., ordered to Naval Academy, Annapolis, Md.

Norfleet, Ernest, P. A. Surgeon, U. S. N., granted sick leave for three months.